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**Exploring the clinical learning experience: Voices of  
Malawian undergraduate student nurses.**

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## ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
BSc	Bachelor of Science
CLE	Clinical Learning Environment
CHAM	Christian Health Association of Malawi
CINAHL	Cumulative Index to Nursing and Allied Health Literature
DoH	Department of Health (UK)
EN	Enrolled Nurse
GDP	Gross Domestic Product
HDU	High Dependency Unit
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
KCN	Kamuzu College of Nursing
KCH	Kamuzu Central Hospital
MoH	Ministry of Health (Malawi)
MSc	Master's Degree
NHS	National Health Service (UK)
NGO	Non-Governmental Organization
NMC	Nurses and Midwives Council (Malawi) & Nursing and Midwifery Council (UK)
NMT	Nurse Midwifery Technician
NONM	National Organisation of Nurses and Midwives (Malawi)
NSO	National Statistical Office (Malawi)
PhD	Doctor of Philosophy
QECH	Queen Elizabeth Central Hospital
RN	Registered Nurse
UK	United Kingdom
UKCC	United Kingdom Central Council for Nurses Midwives and Health Visitors
WHO	World Health Organization

## **DECLARATION**

I declare that this thesis is my own work; and that the research which it reports is also my own work

**Signature**

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**Date**

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**Word Count: 99,399**



## **PREFACE**

That this study would culminate into writing about emotions is something I least expected. It was not until I read the book titled 'The emotional labour of nursing' by Smith (1992), who happens to be my supervisor that I came to know about emotional labour as a concept and this has been the source of my inspiration. I was surprised at the similarities in some of findings between her study and my study, considering that the two studies took place in two different parts of the world. My study was ontological in nature, aiming to explore the 'lifeworld' of student nurses at Kamuzu College of nursing<sup>1</sup>(KCN) in Malawi. As I analysed and tried to derive meaning from the students' narratives, I realised that their accounts eloquently conveyed the emotionally charged situations which confront them during clinical placements and the emotion work they engage in. This instilled in me an interest to know more about emotional labour (Hochschild 1983), a concept under which issues on emotions are commonly discussed in literature. Reflecting on my interactions with KCN students before I commenced my PhD studies, I recollect that I have always been mindful of how I present myself to others; always being mindful that other people also have emotions and endeavouring to present myself to others in a manner that will not hurt their emotions. I remember an incident which happened between one of the faculty members at KCN and the students. At the time, I happened to have been the head for the Medical-Surgical Nursing department and I was responsible for mediation in order to resolve the issue. When I was talking to the students I felt that the discussion was actually arousing negative emotions in me and at that point I stopped them from talking and I remember telling them that whatever they do, they must always bear in mind that we all have emotions. I asked them saying, if we all blow up what would happen? And they unanimously responded back saying there would be a tsunami! This helped to resolve the issue and I now realise that what I was actually telling the students was that they should learn to work on their emotions.

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<sup>1</sup> Kamuzu College of Nursing is a constituent College of the University of Malawi, one of the public universities in Malawi. See figure 1.1 for the geographical position of Malawi within the Map of Africa

## **ACKNOWLEDGEMENT**

A good number of people have contributed to the successful completion of this thesis and I owe my gratitude to all of them. First and foremost I would like to express my profound gratitude to my supervisors. I have had four supervisors during the entire period of my PhD studies and I would like to mention that the change of supervisors which occurred at different periods of my studies was not related to any problems but to circumstances beyond the control of anyone of us. Professor Rosemary Mander and Tonks Fawcett were my supervisors during my first year of PhD studies. By the end of the first year Professor Rosemary Mander retired and Dr Anne Robertson became my principal supervisor whilst continuing with Tonks Fawcett as my second supervisor. I sincerely appreciate the tireless support the three supervisors rendered which enabled me to come up with a robust research project. When I come back from my field work, Professor Pam Smith became my principal supervisor and I maintained Tonks Fawcett as my second supervisor. I want to sincerely thank Tonks Fawcett who has always been there for me from the outset of this work. The work of Professor Pam Smith on emotional labour and her support and guidance have been a source of inspiration enabling me to successfully analyse and interpret my findings and I am sincerely grateful to her. I think she came just at the right time when I needed such support and I am so thankful. I also want to extend my sincere gratitude to my husband Charles and my children Tumbikani, Wongani and Marumbo for their moral support. I wish to sincerely thank my daughter Wongani and my son Marumbo for being there for me when I almost ceased to be a mother in the home. I would also like to express my appreciation to my son Tumbikani for the support he rendered on computer issues and for commenting on some parts of my work. Finally, I would want to express my sincere gratitude to all the students who participated in this study for the rich narrative accounts they gave of their experience which enabled me to develop an understanding of clinical learning in Malawi.

## **DEDICATION**

For my husband Charles and our children Tumbikani, Wongani and Marumbo

## **ABSTRACT**

Very little has been done to define the process of clinical learning in Malawi and yet anecdotal observations reveal that it is more challenging than classroom teaching and learning. This set the impetus for this hermeneutic phenomenological study, the aim being to gain an understanding of the nature of the clinical learning experience for undergraduate students in Malawi and to examine their clinical experiences against some experiential learning models (Kolb 1984; Jarvis et al 1998). The study setting was Kamuzu College of Nursing (KCN) and the sample was selected purposively and consisted of 30 undergraduate students who were recruited through volunteering. Conversational interviews were conducted to obtain students' accounts of their clinical learning experience and an eclectic framework guided the phenomenological analysis. The study raises issues which relate to nursing education and nursing practice in Malawi. From an experiential learning perspective, the study reveals that clinical learning for KCN students is largely non-reflective. The study primarily reveals that the clinical learning experience is enormously challenging and stressful due to structural problems prevalent in the clinical learning environment (CLE). In some clinical settings the CLE appears hostile and oppressive due to negative attitudes which some of the clinical staff display towards KCN students. Consequently, students' accounts depict emotionally charged situations which confront them and this illustrates that clinical learning for KCN students is an experience suffused with emotions. In literature issues on emotions are commonly discussed under emotional labour (Hochschild 1983) and I used the concept as a basis for my preunderstandings and interpreted the students' accounts of their clinical learning experience against such a conceptual framework. What resonated from their narratives was the depth of the emotion work they engage in. This enabled me to arrive at a new and unique conceptualisation of clinical learning redefined in terms of emotional labour within the perspective of nurse learning in Africa. The findings are a unique contribution to the literature on emotions and provide essential feedback which forms the basis for improving clinical learning in Malawi.

## Chapter 1: INTRODUCTION AND BACKGROUND OF THE STUDY

*'One learns to know what one loves, and the deeper and fuller the knowledge is to be, the more powerful and vivid must be the love, indeed the passion' (Goethe 1963:83)*

### 1.1. Introduction

This study took place in Malawi, a country situated in the southern eastern part of Africa, in the area commonly known as the Sub-Saharan region (See Figure 1.1).<sup>2</sup>The study explored the clinical learning experience<sup>3</sup> for undergraduate students at Kamuzu College of Nursing (KCN). Nursing education in Malawi operates on a belief that both theoretical knowledge and practice are essential for the successful preparation of student nurses for their career as future nurses. This implies that both classroom and clinical teaching and learning are accorded equal value. However, there seems to be emphasis on classroom learning and very little has been done to define the process of clinical learning and yet anecdotal observations indicate that it is more complex and challenging than formal classroom teaching and learning. This therefore set the impetus for this study, the purpose being to examine student nurses' perceptions of their hospital based clinical learning experience.

The study reveals that the clinical learning experience is enormously challenging due to structural problems prevalent within the clinical settings in Malawi. There is severe nursing shortage and gross lack of material resources in most clinical settings and the clinical learning environment (CLE) seems to have severely deteriorated. In addition, the study reveals relational problems between students and clinical nurses and these seem to be associated with the fact that KCN students are pursuing a Bachelor's degree, a qualification which most of the practicing nurses do not possess. Consequently, some nurses exhibit negative attitudes towards KCN students and they demonstrate unwillingness to teach them. However, the students are not entirely innocent; they have their own share in the existing relational problems. There is evidence that sometimes students are the ones who instigate clinical staff to develop negative attitudes towards them. All these factors negatively impact on the

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<sup>2</sup> See figure 1.1 on page 8 for map of Malawi

<sup>3</sup> Clinical learning experience refers to the clinical practice experience where students are allocated to various clinical settings for their professional socialization. This is used interchangeably with clinical placement and clinical experience.

clinical learning and are responsible for the emotionally charged situations which confront students during their clinical placements. This illustrates that the clinical learning experience is suffused with emotions and the students' accounts portray a probability of emotion management. In literature issues on emotions are commonly discussed under the concept of emotional labour (Hochschild 1983) and I used this as a conceptual device to interpret the students' accounts of their experience and arrived at a new and unique conceptualisation of clinical learning, redefined in terms of emotional labour within the perspective of nurse learning in Africa. The study therefore contributes to literature on emotions.

## **1.2. Background of the study**

Clinical nursing education is a fundamental component in the pre-registration nursing curriculum (Chan 2001). Its aim is to provide the students adequate time to observe role models, to practice and to reflect upon their clinical experience (Thorell-Ekstrand and Bjorvell 1995). Clinical nursing education takes place in what is commonly referred to as the clinical learning environment (CLE) and literature reflects the complexity of learning in such an environment. Lewin (2007) maintains that the educational situation in hospital wards is intrinsically more complex than that in the School because its primary concern is patient care and not student education. Papp et al (2003) assert that the ward learning environment has a lot of stimuli which makes it hard for the student to identify potential learning opportunities. Similarly, Brown et al (2005) posit that student nurses feel overwhelmed and overcrowded with the diversity of issues within the clinical area such that they do not know what to learn.

Clinical nursing education is in essence learning through experience and it is a type of experiential learning (Elcigil and Yildirim Sari 2007). Kolb (1984) indicates that the simple perception of experience is not sufficient to promote learning. Likewise, Shields (1995) argues that the mere fact of having an experience does not guarantee that learning has taken place. Dewey (1998) asserts that not all experiences are genuinely or equally educative, but rather, some are mis-educative. In view of this, Jarvis et al (1998) claims that responses to the constructed experience vary leading to

different types of learning and these include; non-learning, non-reflective learning and reflective learning. My intention in conducting this study was to examine undergraduate student nurses' perceptions of the nature of their clinical learning.

Clinical nursing education is a core component of the pre-registration BSc Nursing programme at KCN. Clinical learning and teaching are incorporated in each year of study and Central Hospitals<sup>4</sup> are mainly used as teaching hospitals where students are allocated for their clinical experience. These are tertiary level hospitals and are capable of providing adequate learning opportunities in a sense that students are able to encounter patients with the various conditions which they learn in class. This puts classroom learning into a proper perspective and enables students to understand the various health problems in Malawi and how to care for patients with such conditions. However, the teaching hospitals are not without problems. There is congestion of patients as a consequence of an increased disease burden which Malawi is experiencing. Common health problems in Malawi include AIDS, tuberculosis and malaria. HIV infection is rampant and the rate of infection is high among the adult population (15-49 years) and it is estimated at 15 % (MoH 2004). There is severe shortage of nurses in Malawian hospitals and the nurse/patient ratio is at 0.59 nurses per 1,000 people (WHO 2006).

Malawi is one of the poor countries in Sub-Saharan Africa with a GDP of \$8.272 billion (WHO 2009) and as a consequence of this most government hospitals lack material resources for providing comprehensive nursing care. This implies that besides the problem of nursing shortage which is prevalent in most clinical settings, KCN students gain their clinical experience in resource poor settings. This is contrary to the requirement for effective clinical learning. Marrow (1997) maintains that enabling student nurses to develop fully in the clinical setting demands adequate resources especially in the form of manpower and Shailer (1990) points out that the availability of resources is also significant in determining the quality of the learning process and the outcome. I contend that poverty, nursing shortage and HIV/AIDS

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<sup>44</sup> Central hospitals are government hospitals and they are tertiary level hospitals which mean that they are capable of providing specialist care and they serve as referral hospitals. Malawi has four central hospitals which include Kamuzu Central Hospital (KCH), Queen Elizabeth Central Hospital (QECH), Zomba Central Hospital and Mzuzu Central Hospital

pandemic negatively impact on health care delivery and nursing education in Malawi. Indisputably, caring for patients in resource poor settings is challenging hence it was essential to conduct this study in order to determine the students' perceptions of their clinical learning experience.

This study had its origins in my own reflective and reflexive concerns as a lecturer at Kamuzu College of Nursing. As a nurse lecturer, I perceived clinical teaching to be more challenging than classroom teaching because of problems I encountered in the clinical settings during clinical supervision. I personally felt that the problems added to the complexity of clinical learning, which is inherently known to be stressful and challenging. This happened during the time I was head of the Medical-Surgical Nursing department and I was directly responsible for the implementation of medical and surgical nursing components of the curriculum for pre-registration students. With such an exposure to the curriculum, I was able to identify the gap that existed between theory and clinical nursing education and how this impacted on students' clinical learning.

The other factor which prompted me to conduct this study is the fact that in Malawi the clinical learning experience has not been clearly defined. Both KCN as an academic institution and Nurses and Midwives Council (NMC), a regulatory body, put more emphasis on teaching and assessment of theory than on clinical nursing education. This is evidenced by the way clinical competence is assessed, which is largely on the basis of a student performing well during written examinations. The Council, as a regulatory body provides the syllabi for the theory components and only prescribes the hours of clinical practice without specifically indicating the competencies to be attained at each level. Not much guidance is provided for clinical nursing education and this makes clinical learning to be ill defined and difficult to facilitate.

Turale et al (2008) indicate that nursing education practices may share similarities while at the same time there are some distinctions from country to country. Thus, although the clinical learning experience has been sufficiently explored in the UK,

Australia and other western countries, it was still needful to conduct this study in Malawi and its findings contribute to a body of nursing knowledge that specifically addresses issues of nursing education from an African perspective. The challenges which confront nurse learning in African countries are in themselves unique and different from those experienced in western countries and therefore there should be a body of knowledge to this effect. In addition, it should be noted that in the 'lifeworld' of a student nurse, the clinical learning experience is significant and understanding this experience has itself pedagogic implications. In this study I addressed the following central, overarching research question and sub questions:

### **Main Research Question**

1. What is the nature of the clinical learning experience for undergraduate student nurses at Kamuzu College of Nursing (KCN)?

### **Sub questions**

- (a) How do undergraduate student nurses at KCN perceive their clinical learning experience?
- (b) How do they perceive the clinical learning environment?
- (c) What do student nurses perceive that they learn during the clinical experience?
- (d) How do they learn?
- (e) What facilitates or hinders their clinical learning?

These questions were the impetus for this hermeneutic phenomenological study and to this end, Van Manen (1990:42) wrote:

To do a phenomenological enquiry is to question something phenomenologically and, also, to be addressed by the question of what something is really like. What is the nature of the lived experience?

The aims of the study evolved to be to gain an understanding of the nature of the clinical learning experience for undergraduate student nurses at KCN and to examine their clinical experiences against some experiential learning models (Kolb 1984; Jarvis et al 1998). In the next subsection I discuss nursing education in Malawi and I hope that this will enable the reader to have an understanding of the context in which clinical nursing education in Malawi operates.



### **1.3. Nursing education in Malawi**

Presently there are two main institutions in Malawi offering nursing education at tertiary level and these include Kamuzu College of nursing, a constituent College of the University of Malawi and Mzuzu University. However, nursing training in Malawi started as early as 1889 by missionaries. This was not a formal type of training and candidates of such training become nurse auxiliaries. In 1965 the National School of Nursing was established for the training of registered nurses (RNs) and candidates who qualified from this programme were awarded certificates in nursing and midwifery. In 1979 Kamuzu College of Nursing (KCN) was established as a constituent College of the University of Malawi. This was in response to a directive by the first president of Malawi Dr H. Kamuzu Banda. Whether the nursing profession was ready for such a move or not, the president's directive was honored. Arguably, this development brought an effortless<sup>5</sup> advancement for the nursing profession in Malawi which may have facilitated professional growth.

The initial KCN programme took four years and upon completion candidates were awarded a diploma in nursing and a university certificate in midwifery. In 1996 a Bachelor of Science (BSc) Nursing Programme commenced at KCN, marking the beginning of undergraduate nursing education in Malawi. Presently, KCN also offers post basic nursing programmes leading to Bachelor's degree in the following areas; Nursing education, Nursing management and Community health nursing. Since 2008 KCN has witnessed the commencement of three Masters (MSc) Programmes and these include Clinical MSc in midwifery, Clinical MSc in child health nursing and MSc in reproductive health. KCN has its main campus in Lilongwe, the capital city of Malawi and a satellite campus in Blantyre. The College utilizes Queen Elizabeth Central hospital (QECH) in the southern region and Kamuzu Central hospital (KCH) in the central region as the main teaching hospitals (see figure 1.1). However, sometimes students also have clinical placements at Mzuzu central hospital in the northern region.

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<sup>5</sup> This is unlike other countries where nurse educators had to contend with those who opposed such a move both within the profession and opponents outside the profession whereas in Malawi such a transition occurred as a presidential directive

In 1997 Mzuzu University was established as a second public University in Malawi. It is situated in Mzuzu, in the northern part of Malawi (see figure 1.1). The university established a faculty of Health Sciences in 2006 and this led to the commencement of a pre-registration nursing and midwifery programme. Presently, the pre-registration BSc Nursing Programmes for both KCN and Mzuzu University constitute a four year integrated<sup>6</sup> program. This is an attempt to respond to the country's high maternal mortality rate which is at 984 deaths per 100,000 live births (National Statistical Office 2005). Nonetheless; the integrated programme does not apply to the cohort of students who participated in this study.

Malawi also has other nursing Colleges which are responsible for the training of NMTs.<sup>7</sup> These include nine institutions under Christian Health Association of Malawi (CHAM) and one government training institution under the Ministry of Health (MoH). CHAM is an ecumenical, non-governmental umbrella organization of Christian owned health facilities. The CHAM training institutions produce about eighty per cent of the nurses in Malawi, all of them being NMTs. Further discussion on the training of NMTs is beyond the scope of this study. I only explored the clinical learning experience of undergraduate students mainly because of my involvement with this group of students. The concerns I had as I interacted with KCN students during their clinical placements prompted me to conduct this study. Initially I had thought of including students from Mzuzu University as well but what prevented me is the fact that its nursing programme is fairly recent and the students' experiences may not be as comparable. I therefore focused on KCN students only in order to have a homogeneous sample.

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<sup>6</sup> The integrated programme refers to inclusion of nursing and midwifery components into the curriculum to produce graduates with dual qualification namely, nurses/midwives. Students start by learning nursing modules but at some point within the programme modules for both nursing and midwifery components run in tandem.

<sup>7</sup> NMTs stands for Nurse midwifery technicians, a cadre of nurses lower to Registered nurses and such nurses were previously called enrolled nurses (ENs)

**Figure 1.1: Map of Malawi**



Nurse lecturers and clinical nursing staff participate in the facilitation of clinical learning in Malawi. The ward sister and sometimes matrons are the only leadership positions within the practice setting that are directly responsible for students' clinical learning. O'Driscoll et al (2010) reflect other leadership positions which are directly linked to students' education and practice learning such as clinical nurse specialists, nurse consultants, and nurse practitioners. However, these positions do not exist in Malawi. The majority of the nurses in Malawi are enrolled nurses (ENs) and are presently called nurse technicians (NMTs). Aukerman (2007) cites statistics of nurses in Malawi which reflect three hundred and eighty four registered nurses (RNs)

and one thousand eight hundred and thirty four enrolled nurses working in government hospitals. This might mean that nursing students interact closely with ENs than with RNs and this might have implications on the quality of the clinical learning experiences. The enrolled nurses may be good at assisting student nurses to develop psychomotor skills but may lack the ability to promote development of analytical and critical thinking skills. Hegarty et al (2008) indicate that undergraduate programmes should enable student nurses to develop skills in analysis, critical thinking, problem solving and reflective practice. This requires that those facilitating clinical learning should operate at such a level.

Nursing education in Malawi is regulated by the Nurses and Midwives Council of Malawi. The Council provides the syllabi for Registered nurses and annually inspects the nursing educational institutions to ensure that prescribed standards are met. The Council also prescribes the total number of hours that each student should accomplish during the entire educational programme and for the undergraduate programme this includes one thousand nine hundred and sixty hours of theory and three thousand and three hundred hours of practice (Nurses and Midwives Council of Malawi syllabus for registered nurses unpublished). In addition, the Council administers a licensure exam to graduates which enables them to practice as qualified nurses.

The pre-registration BSc programmes being offered at both KCN and Mzuzu University and also the post basic degree programmes at KCN are positive developments for nursing education in Malawi. However these programmes do not fully address the issue of expanding roles of the nurse/midwife. As Carlisle (2005) points out, this is an age of new and expanded roles for the nurse. The post basic degree programmes being offered at KCN have a focus on nursing education, nursing management, community health nursing and midwifery. These programmes do not promote development of clinical career pathways<sup>8</sup> for nursing and midwifery practice and it seems appropriate to conclude that this has partly contributed to the massive exodus of nurses from the practice setting. The challenges for the health care

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<sup>8</sup> A clinical career pathway allows professional advancement of clinical nurses which is essential to retain the nurse at the patient's bedside, doing bedside care.

system in Malawi are enormous and therefore nursing educational institutions need to rise up to the challenge by developing programmes which promote expansion of the nurses' and midwives' roles. There is need to develop programmes aimed at producing specialist and advanced nurse and midwifery practitioners. To this end, Castledine (2000) recommends that it is the responsibility of nursing education in collaboration with practice settings to shape practice. It is hoped that the Clinical MSc programmes in Midwifery and child health that have recently commenced at KCN will respond to this challenge.

I have included an outline of what is contained in the subsequent chapters for the reader to know what to expect. Chapter two reflects the literature review for the study. The clinical learning experience is a form of experiential learning which takes place in what is commonly known as the clinical learning environment (CLE). Nurse lecturers, clinical nursing staff and students themselves are the key stakeholders who significantly influence clinical learning. The literature review therefore includes a substantial discussion of these issues. Chapter three depicts the methodology and methods which were employed in the conduct of this study. In addition, I have also discussed philosophical tenets which underpin the study and other issues pertinent to the conduct of research.

In chapters four to seven I present the study findings in exactly the way participants narrated their experiences. The themes I identified in these chapters reflect what was of salience in the participants' minds and words that are repeated powerfully convey this. For example, the phrase 'we cover shortage' was a constant theme among the participants. Some of the themes were identified basing on a phrase from one participant, which clearly captures what the other participants expressed. Typical examples in this case include the themes 'learning in a hard way' and 'lost sheep'. 'The findings in chapters' four to seven portray the Shared meanings which have been identified as constitutive patterns and themes.

Diekelmann (1992) indicates that a constitutive pattern expresses the relationship among themes, and four constitutive patterns have been identified which include; clinical learning in Malawi: problems and challenges; experiencing clinical learning;

student related factors in clinical learning and the nature of the clinical experience. In a hermeneutic phenomenological study, the role of the researcher is to interpret participants' narrative accounts of their experience. The accounts of students who participated in my study portray the emotionally charged situations which confront them during clinical placements and I used emotional labour (Hochschild 1983) as a basis my preunderstandings and interpreted the study findings against such a conceptual framework. Chapter eight is an exhaustive discussion on emotional labour as it applies to nurse learning in Malawi. Chapter nine is the final chapter and includes a summary of findings and an extensive discussion of proposed recommendations to improve clinical learning in Malawi.

## **CHAPTER 2: EXPERIENCE AND CLINICAL LEARNING: A REVIEW OF LITERATURE**

### **2.1. Literature search strategy**

Initially the Cumulative Index to Nursing and Allied Health Literature (CINAHL) electronic database was searched using “clinical learning experience” as the key word and these yielded 23 sources. These were both relevant and non-relevant items. Inclusion criteria for selection of items included items which focused on clinical experience, clinical learning and the clinical learning environment. The period of publication was also used as an inclusion criterion where the aim was to get items from around the years 2000-2008. However, in some cases items around the 1990s, more especially 1995-1999, where the item appeared quite relevant and important for the study were also used. Boolean logic was also used with the following key words 'Nurse teacher AND Clinical learning experience' which yielded 2 sources, 'Clinical nursing staff AND Clinical learning experience' yielded no results and 'Student nurses AND Clinical learning experience' yielded 5 sources. Some of the sources could not be accessed through Edinburgh University library and in addition, the items accessed were not enough for a literature review therefore another search was conducted through Medline. 'Clinical learning for student nurses' was used as the key word and this yielded 507 sources. These were also both relevant and non-relevant items and the same inclusion criteria as above were used. Quite a good number of sources for the literature review were identified through the ancestry approach. This involves using citations from relevant articles or books to track other relevant literature sources (Polit and Beck 2008).

### **2.2. Introduction to literature review**

This literature review is a critical analysis of pertinent issues surrounding the student nurses' clinical learning experience. The clinical experience is a learning experience for student nurses. This is a case where learning is derived from experience and this necessitates that clinical learning should be underpinned by experiential learning theory. In view of this, the literature review includes a discussion on experiential learning theory. Literature also reflects that experiential learning is facilitated

through reflection (Boud 1985; Dewey 1998) and there is a plethora of literature to this effect. I have therefore substantially discussed some issues and problems of reflection and reflective practice. The literature review also includes a discussion of other specific issues that relate to the clinical learning experience and these include learning in the ward setting, the roles of the nurse lecturer, and clinical nursing staff and student nurses in the promotion of clinical learning. There is a paucity of literature on clinical learning from a Malawian or African context. Therefore, the literature which supports this study is mainly from international sources and more specifically from the UK and Australia. Literature sources around the 1980s to 1990s reflect issues similar to the current nurse education system in Malawi and although such literature may seem outdated, it is still quite relevant for the Malawian situation. The literature discussed informed this study in a sense that it shaped theoretical and conceptual assumptions which have been crucial in enabling me to interpret and understand the clinical learning experience for KCN students. This substantially contributed to my foreknowledge or preunderstandings on clinical learning besides my personal experience. In a hermeneutic phenomenological study the researcher's preunderstandings helps in the interpretation of study findings enabling the researcher to understand the phenomenon being investigated. This literature review includes a discussion of the following issues: experiential learning theory, reflective learning, and experiential learning model by Jarvis (1998); learning in the ward setting and the roles of nurse lecturers, clinical nursing staff and students themselves in clinical learning.



### **2.3. Experiential learning theory**

Experiential learning is a constructivist theory of learning whereby social knowledge is created (Kolb and Kolb 2005). The theory reflects an interrelationship between experience and learning and the learning is called experiential to emphasize the fundamental role that experience plays in the learning process (Kolb 1984). Jarvis (2003:54) defines experience and he states:

Experience is subjective and a form of thought, but those thoughts are constructed and influenced both, by our biography and by the social and cultural conditions within which they occur.

The definition clearly reflects the subjective nature of experience. However, the fact that experience is a form of thought makes it rather passive. Experience should be more than a thought. Boud and Miller (1996) define experience as the way in which humans sense the world and make sense of what they perceive. This definition reflects that experience has to do with perceptions but it is not quite exhaustive. Experience also has to do with activities and emotions. Therefore, I would define experience as the perceptions and emotions of an individual as s/he interacts or gets involved with his/her immediate world.

Experiential learning in higher education can be traced to the educational philosophy of John Dewey (Kolb 1984). Dewey reveals that there is an intimate and necessary relationship between the process of actual experience and education and that the learning that takes place from experience is dependent on the quality of the experience. However; Dewey (1998) also argues that not all experiences are genuinely educative, but rather, some are mis-educative. This view was also echoed by Shields (1995) who indicates that the mere fact of having an experience does not guarantee that learning has taken place. It is important to mention that mis-educative clinical learning experiences can indeed occur and do occur, and this calls for nurse educators to be proactive in order to prevent such occurrences. This is why Fowler (2008) concludes that experience is not just a simple matter of exposure to an event but that the element of the experience needs to be positioned in line with the existing knowledge and experiences. McGill and Warner Weil (1989:248) define experiential learning as:

The process whereby people, individually and in association with others, engage in direct encounter and then purposefully reflect upon, validate, transform, give personal and social meaning to and seek to integrate the outcomes of these processes into new ways of knowing, being, acting, interacting in relation to their world. Experiential learning therefore enables the discovery of possibilities that may not be evident from direct experience.

This definition is quite broad, reflecting the diversity of meanings of experiential learning and incorporates all the different ideologies and practices of experiential learning. Parker et al (1995) define experiential learning as a process in which a particular experience is translated into concepts which become guidelines for new experiences through reflection. Literature reveals that the simple perception of experience is not sufficient for learning to take place but something must be done to it (Kolb 1984; Boud et al 1985). Knowledge develops from the combination of grasping and transforming the experience (Kolb 1984). Kolb (1984) describes the process of experiential learning as comprising of a four- stage cycle which includes; concrete experience, reflective observation, abstract conceptualization and active experimentation and that the learning process lies in the transactions among these. Concrete experience and abstract conceptualization enable the learner to grasp the experience while reflective observation and active experimentation transform the experience (Kolb and Kolb 2005). The crucial role that reflection plays in experiential learning is clearly portrayed. To this end Boud et al (1985) support that reflection is the key concept that turns experience into learning. Fowler (2008), also recognizing the important role of reflection, asserts that in experiential learning, the learning results from an experience of a certain quality, with meaningful reflection. This indicates that the quality of the experience and the nature of reflections determine the learning that will take place.

## **2.4. Reflective learning**

Reflection and reflective practice have become contemporary nursing practice issues in the UK and other western countries (Burton 2000) and this development was influenced by the need to have nurses who are capable of critical thinking (Pierson 1998). This need arose among British nurses because of the recommendation by the United Kingdom Central Council of Nursing, Midwifery and Health Visiting (UKCC), that the future nurse practitioner should be a 'knowledgeable doer' and a thinking person with analytical skills (UKCC 1986). The need for practice-based theory was also instrumental to the adoption of the concept of reflection and reflective practice (Stockhausen 2006; Mallik 1998; Rolfe 1997). It is argued that this recommendation does not only apply to British nurses but to professional nurses globally. In the UK nursing academia has not been left out in this development and reflection has been embraced as a source of insight, learning and knowledge (Epp 2008). Baker (1996) reveals that reflection leads to increased sensitivity to the environment and makes the student nurses to question any puzzling experience.

The concept of reflection is represented by different terms such as reflective learning, reflective writing and reflective practice (Moon 2004). Reflective learning aims at promoting learning through reflection whereas reflective practice emphasizes the use of reflection in promoting professional development (Moon 2004). Boud et al (1985) define reflection as the intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understanding. This definition reflects that both the intellectual and affective activities are involved. This is Important considering that reflection occurs following a situation which is problematic and makes one to be puzzled, surprised or uncomfortable (Atkins and Murphy 1993; Dewey 1998).

Schon (1930-1997), an educational theorist, identified two types of reflection which he termed; reflection-in-action and reflection-on-action. He defines reflection-in-action as a process of internally dialoguing with the situation as it unfolds. According to Schon, the internal dialogue is provoked by surprise, or a puzzling event within the situation. Schon viewed reflection-in-action as a unique feature of expert

practitioners who are able to experiment and think about practice while they are doing it (Bulman 2004). Stockhausen (2006) illustrates the use of reflection-in-action in clinical teaching in a study which explored how experienced practitioners teach undergraduate nursing students. She identifies *métier* artistry as a newly discovered dimension to reflection-in-action which displays artistry of practice and is demonstrated by registered nurses during clinical teaching encounters. She reveals that this exposes the students to the deep intrinsic professional artistry of practitioners and that more often in such teaching or learning encounters neither the registered nurse nor the student appears actively aware of a potential teaching or learning event as the artistry of practice occurs. Schon (1987) defines reflection-on-action as thinking back on what we have done. Similarly, Burton (2000) views reflection-on-action as a cognitive post-mortem where one looks back at past practice. Reflection-on-action therefore takes place retrospectively and could be easily facilitated among student nurses to promote experiential learning.

Reflection does not occur automatically (Reiman 1999), there is need to utilise innovative teaching strategies and these include: reflective practice diary (Heath 1998); reflective practice groups (Platzer et al 2000); action learning group (Graham 1995); reflective journal writing (Baker 1996); critical incident analysis (Parker et al 1995). In addition, Jarvis (1992) recommends that structures should exist within which reflection can occur and in support of this notion; Pierson (1998) asserts that providing student nurses time to reflect-on-action is an important consideration for nurse educators. May and Veitch (1997) revealed in a study that formal opportunities within programmes for students to reflect on their placement experiences affects the educational potential of students' placement based education. Frameworks to promote reflection are also a necessary prerequisite and these help to ensure that the reflective activity encourages synthesis, analysis, critical thinking and evaluation (Burrows 1995; Burton 2000). Some of the frameworks include Gibbs (1988) reflective cycle and Driscoll's model of reflection (see Appendix H).

## 2.5. The experiential learning model by Jarvis

The experiential learning model by Jarvis (1998) is essential to this study as it provides a yard stick to examine the clinical learning experiences of KCN students from an experiential perspective. I must admit this is not the most recent work by Jarvis but the model has been chosen because of its simplicity. Jarvis's current philosophical stance on experiential learning sounds quite complex to be used in a study which is broadly guided by another theoretical perspective and it is on this basis that I could not use it in my study. Jarvis et al (1998) reveal that responses to the constructed experience vary leading to different types of learning which include non-learning, non-reflective learning and reflective learning and these provide a simple way of examining students' clinical learning (see Table 2.1 below).

**Table2.1: A typology of learning**

Category of response to experience	Type of learning/non learning
Non learning	Presumption Non-consideration Rejection
Non-reflective learning	Preconscious learning Skills learning Memorization
Reflective learning	Contemplation Reflective skills learning Experimental learning

**Jarvis et al (1998, p51)**

### **Non-learning**

According to Jarvis et al (1998) presumption is atypical response to everyday experience where individuals presume upon the situation and do not learn from it. Presumption involves trusting that the world will not change. Non-consideration occurs when people do not respond to potential learning experience. In such cases individuals do not consider the situation and therefore do not learn from it. Jarvis et

al (1998) indicate that this occurs because of busy schedules which hinder reflection on the experience, fear of the outcome or failure to comprehend the situation. Some of the sources of fear may include inapproachability on the part of nursing teachers and clinical nursing staff. Rejection causes non-learning from potential learning experiences. This is associated with complexity of the experience therefore the individual do not seek to understand the situation or the experience. The authors recommend that when planning and organizing clinical placements there should be a balance between complexity of the clinical area and level of the students and that some degree of complexity is required to promote critical thinking and deeper approaches to learning.

### **Non-reflective learning**

This is learning from experience that lacks reflection and includes preconscious learning, skills learning and memorization. Preconscious learning occurs incidentally, it is not planned and the learning does not become conscious knowledge. In such cases there is exposure to a situation but with low awareness (Jarvis 2006). Jarvis et al (1998) indicate that there is a lot of knowledge embedded in the students clinical practice experience but a lot of it does not become conscious knowledge and therefore students are vaguely aware of it. Nursing as a practice-based profession involves a lot of skills learning to promote mastery of procedures and Jarvis et al (1998) indicate that skills' learning is often acquired through imitation and role modeling. Memorization occurs when students are given all the information and such a practice promotes a surface approach to learning because it hinders an enquiring spirit. Jarvis et al (1998) also indicate that non-reflective learning perpetuates the traditional routines of the profession and hinders professional growth.

### **Reflective learning**

Jarvis et al (1998) indicate that reflective learning includes contemplation, reflective skills learning and experimental learning. Contemplation is the process of thinking about an experience (Jarvis et al 1998). The authors assert that reflective skills' learning is regarded as a more sophisticated approach of learning practical subjects. This does not only involve learning the skill but also learning the concepts that

underpin practice. Reflective learning is significant in nursing education because it promotes knowledge development which can underpin and improve practice. Reflection is important in nursing education because it encourages students to become thoughtful individuals capable of critical and innovative thinking (Pierson 1998).

## **2.6. Learning in the ward setting**

Literature reveals that the clinical learning environment (CLE) still remains important to clinical nursing education (Midgley (2006); Chan and Ip 2007). Massarweh (1999) refers to the CLE as the clinical classroom. Chan (2001) defines the ward-learning environment as a multidimensional entity that directly affects the outcomes of students' clinical placements. In support of this notion, Papp et al (2003) indicate that the clinical environment encompass all that surrounds the student nurse, including the clinical settings, the equipment, the staff, the patients, the nurse mentor and the nurse teacher.

Inherent within nursing education is the clinical practice experience, which is essential for integration of theory to practice (Jackson and Mannix 2001); development of nursing practice skills (Nolan 1998); and development of professional competence, independence and self-directedness (Papp et al 2003). Cope et al (2000) report findings of a retrospective study which confirm the significance of the clinical practice experience for student nurses. The study examined placement experiences of nurses who had just completed their training and the findings revealed that the main significance of a placement was to place learning into a meaningful context. The placement gave meaning to the assimilated knowledge as the students encountered the real life situations and hence promoted learning. Koh (2002) revealed in a study that the quality of learning is conversely proportional to the quality of the clinical experience (Koh 2002).

Papp et al (2003) conducted a phenomenological study which was aimed at describing Finnish student nurses' perceptions of clinical learning experiences in the context of the clinical learning environment. The findings revealed that the clinical environment is significant for learning and that a good clinical learning environment is one where there is good co-operation between staff members, a good atmosphere and where students are regarded as younger colleagues. The results also revealed that when the support from nursing staff regarding the planning and implementation of practical nursing situations was inadequate clinical learning was experienced as difficult. This therefore reflects that student support is a necessary prerequisite for clinical learning.



Cheraghi et al (2008) explored factors influencing the clinical preparation of BS nursing student interns in Iran using the grounded theory approach. Three main themes emerged from the study which includes educator incompetency; nursing staff technical ability and a non-conducive learning environment. The study revealed that lack of clinical experience and specialty training among academic clinical educators was the most important factor that hindered their ability to educate students effectively. The technical skills of the staff appeared to be an important obstacle against utilizing new approaches such as the nursing process and holistic care. The clinical learning environment was found not to be conducive and fruitful to the clinical learning for the students. Students lacked qualified educators for guidance, and experienced an unsupportive and non-scientific relationship by the staff nurses. The study also revealed that the most supportive and positive clinical environment with up-to-date staff and competent clinical educators significantly impact on the clinical experience for nursing students, allowing them to integrate theory to practice.

Dunn and Hansford (1997) used a multi-method design to explore the undergraduate nursing students' perceptions of their clinical learning environment (CLE). The clinical learning environment scale (CLES) was used to obtain quantitative data while qualitative data were collected through focus group discussions. Five factors were identified through CLES and these were used to guide the integration of quantitative and qualitative data and include; staff-student relationship, nurse manager commitment to teach, patient relationships, student satisfaction and hierarchy and ritual. The findings revealed that interpersonal relationships between the various parties in the clinical learning environment significantly influence the development of a positive learning environment. A warm and supportive relationship between staff and students, support provided in gaining access to learning experiences and willingness to engage in a teaching relationship by clinical staff were quite significant in the development of a positive clinical learning environment.

Nolan (1998) conducted a descriptive, interpretive qualitative study which was informed by critical social science. The study revealed that students need to fit into the social environment of the clinical setting and be accepted by staff and clients in

order for them to be able to learn from the clinical experience. Cope et al (2000) also revealed the importance of acceptance of students by Clinical nursing personnel. The authors categorised acceptance into social and professional acceptance and indicated that social acceptance is quite significant and may be attained before the student can demonstrate any competence. Nolan (1998) also revealed that the failure to fit-in and belong compromises clinical learning because students spend their time making efforts to fit-in. She asserts that under such circumstances learning is hindered because students simply conform to what is expected of them by the Clinical nursing staff in an attempt to fit-in and that they utilize strategies such as maintaining a low profile and avoiding challenging questions.

Levette-Jones and Lathlean (2008) explored nursing students' experience of belongingness while on clinical placements and the study revealed that belongingness influenced and motivated students to engage in clinical learning opportunities. To this effect Levette-Jones and Lathlean (2008:107) wrote,

Students felt more empowered and enabled to capitalise on the available learning opportunities when they felt they had a legitimate place in the nursing team and they were often more self-directed and independent in their approach.

The authors assert that the registered nurses with whom student nurses interact with in the clinical setting influence their sense of belonging and learning. They also revealed that lack of belongingness creates anxiety and apprehension and negatively impacts on the students' attitude to learn and their confidence to engage in experiential learning opportunities. Levette-Jones et al (2009) also conducted a cross national comparative study which utilised the mixed method approach to explore the concept of belongingness and the findings revealed that positive staff-student relationships are essential for students to feel accepted, included and valued. Literature also reflects that length of clinical experience is also one of the most influential factors in the development of sense of belonging (Mallik and Aylot 2005; Mallaber and Tuner 2006). Cope et al (2000) report that short placements hinder familiarization of the student nurse with the nursing team in the clinical setting and therefore causes the student nurse to lack a sense of 'membership.' However,

Mallaber and Turner (2006) contend against a system of prescribing a specified number of hours of clinical experience to be attained by student nurses during the entire educational programme. For example, in the UK students are required to demonstrate the completion of 2300 hours of clinical placement (Mallaber and Turner 2006) and Nursing education in Malawi also has a similar system in place<sup>9</sup>. They argue that such a system is a prototype of the apprenticeship model where success was measured by hours served rather than successful achievement of the designated assessment. The argument by Mallaber and Turner (2006) is quite valid because sometimes this causes repetition of some of the clinical placements in order to achieve the required hours. According to Jarvis (2006), levels of consciousness for repetitive actions within experiential learning might be high or none. This means that learning may or may not occur with repetitive action. Arguably, repetitive actions do not motivate students most of the times and therefore might not be associated with any learning.

The clinical learning experience is inherently stressful, and anxiety and apprehension hinder experiential learning because they prevent the student from acting consciously and reflecting on actions (Jarvis et al 2003). Literature reflects studies which have examined stress and anxiety among nursing students. In Malawi, Simukonda and Rappsilber (1989) conducted a study which explored anxiety among male nursing students at Kamuzu College of Nursing. The results revealed that male nursing students experience high level of anxiety due to lack of information about nursing and the college prior to their admission, difficulty in understanding and learning nursing science content and contact with medical assistants and clinical officers in the clinical setting who most commonly are male.

Jimenez et al (2010) identified three major sources of stress which include academic, clinical and external stressors. Academic stressors include assignments and the associated workload, exams, grade anxiety or fear of failing and relations with academic staff. Clinical stressors include patient suffering or death, lack of clinical competence and relations with clinical staff. External stressors include factors which

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<sup>9</sup> See discussion under nursing education in Malawi on page 9

interfere with daily life and financial problems. Some of these stressors were identified in the following studies; lack of clinical competence and fear of making a mistake when caring for patients (Hamill 1995; Neary 1997; Burnard et al 2008), lack of support with clinical learning (Burnard et al 2007), lack of practical skills and negative attitudes of ward staff (Hamill 1995), death of a patient (Rhead 1995; Thyer and Bazeley 1993; Timmins and Kaliszer 2002b, Burnard et al 2008), interpersonal relationships with clinical staff (Evans and Kelly, 2004; Hamill, 1995; Thyer and Bazeley 1993; Timmins and Kaliszer 2002b) and academic staff (Thyer and Bazeley 1993; Timmins and Kaliszer 2002b), financial stressors (Brown and Edelman 2000; Lo 2002; Thyer and Bazeley 1993; Timmins and Kaliszer 2002b).

Assessment strategies also have an influence on students' learning in general. Biggs (1999) claim that what students learn and how they learn depends on what they perceive will be assessed. He asserts that students can engage in deeper or surface approaches to learning depending on how they perceive they will be assessed. Although Biggs discussed students' learning from a perspective of general education, it is argued that a similar trend would be observed with clinical nursing education. To this end, Tawiri et al (2005) conducted a study which examined students and teachers perceptions of what is learned during the clinical practicum and the role played by assessments in influencing learning. The study findings revealed that assessment tasks largely influenced what was learnt and that learning was limited to knowledge and skills directly related to assessment tasks. The assessment task dictated what was learnt and the approach to learning. The type of assessment can significantly influence students on whether to adopt deeper or surface approaches to learning. To this effect Tawiri and Tang (2003) identified that portfolio assessment has a potential to motivate students to a deep approach of learning.

Outcomes of a clinical learning experience are not always positive and a study by Lee and French (1997) reflects this. The two researchers examined the ward-learning climate in Hong Kong and the results revealed that the practice experience was not an educational experience because it did not promote intellectual development. Students lacked qualified teachers for guidance and supervision and students

themselves largely initiated learning. It may be argued that this justifies the fact that the practice experience was not an educational experience because there was no facilitation of learning. Papp et al (2003) revealed that student support is a crucial element of the clinical learning experience. However, Cheraghi et al (2008) reveal that the availability of support in itself is not sufficient to promote clinical learning but that there should be scientific relationships where educators and clinical nursing personnel should engage in scientific discussions. Orland-Barak and Wilhelem (2005) also reflect outcomes of clinical learning in a study which examined student nurses' perspectives towards learning to become a nurse as revealed through the language and content of written stories of clinical practice in an apprenticeship context of nurse training in Israel. The findings revealed procedural professional language, a medical register of language and actions rather than interactions. Procedural professional language was evidenced by step by step accounts of nursing procedures and the stories were devoid of reflection.

## **2.7. Student support: role of the Nurse Lecturer**

The role of the nurse teacher or lecturer<sup>10</sup> in clinical learning has been an area of long standing debate, more especially in the UK and other western countries (Webster 1990; Osborne 1991; Acton et al 1992; Elliot and Wall 2008). Although such debates and discussions have tended to focus on the British nursing education system, I would argue that these issues are relevant to any country where nursing education is offered within tertiary education. Debates are reflected in literature in relation to the issue of nurse lecturers' engaging in clinical practice and maintaining their clinical credibility (Fisher 2005). Debates within the British nursing education system ensued in response to government policy on nursing education which stressed the need for nurse lecturers to maintain their clinical role (Fisher 2005). What influenced policy changes and the debates that followed is the existence of nursing within tertiary education. This change in the nursing education led to concerns about the adequacy of clinical nursing education (Mallik and Aylott 2005). Concerns also followed about the clinical competence of the project 2000 graduates and this led to a recommendation that nurse lecturers should have recent practical nursing experience (Barret 2007).

Literature reflects a dichotomy of views regarding the role of the nurse lecturer. Some are proponents of a more clinical orientation (Webster 1990; Charlesworth et al 1992) and others support an educationalist orientation (Osborne 1991; Acton et al 1992). Webster argues that clinical credibility of nurse teachers is essential if students are to become competent practitioners and this view is echoed by others. This calls for nurse academicians to engage in clinical practice which will help them to keep up to date with current nursing practice so that what is taught in theory relates to what is carried out in practice (Cave 2005; Elliot and Wall 2008). This would also help them to maintain clinical competence and confidence as well as to deliver clinically relevant teaching which is based on recent practice (Bently and Pegram 2003). Saxe et al (2004) contend that clinical practice provides an opportunity among academics to maintain and enhance their skills which may augment their mentoring skills for students. Humphries et al (2000) claim that nurse

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<sup>10</sup> The words nurse teacher and nurse lecturer and clinical supervisor are used interchangeably implying a nursing faculty member with a responsibility of facilitating learning in the clinical setting

lecturers' involvement in clinical practice allows translation of theory to practice. The arguments in support of nurse lecturers engaging in clinical practice seem to be quite persuasive and compelling but literature indicates that institutions of higher learning attach greater significance to research, publication and grant funding and clinical practice is not a criterion for promotion or tenure therefore and there may be no motivation for the clinical role (Ward 2001; Meskell et al 2009). Furthermore, clinical practice adds more workload on nurse lecturers (Langan et al 2003).

Acton et al (1992) support the development of nurse teachers as educationalists and that their role should be that of facilitating and supporting clinical learning. Osborne (1991) indicates that the role of nurse teachers is complex such that in an attempt to fulfil all the roles, they will spread themselves thinly leading to poor quality of clinical learning experiences. She suggests that nurse teachers would be able to offer more constructive support by enhancing their educational skills in supporting ward staff so as to create a positive clinical learning environment. Osborne therefore recommends that nurse teachers should stop trying to remain clinically up to date but should utilise and develop their educational skills in supporting ward staff and this is also echoed by others (Crotty 1993; Forrest et al 1996; Meskell et al 2009; McSharry et al 2010). Acton et al (1992) contend that the continual presence of nurse teachers within the clinical area could be considered as doubling up of roles and resources. I would argue that this only applies where there is an effective mentoring system, but in countries where there is severe nursing shortage, striking a balance on ensuring clinical and educational credibility would be a better approach. In such cases I would suggest it is worth considering the following sentiments which were expressed by (Webster 1990, p16) who wrote:

We must recognise that patient care is their first priority, and we must ensure that in sharing our teaching responsibilities with clinical staff we do not demoralise them or lose their co-operation.

Ioannides (1999) supports that clinical staff as mentors to students are able to initiate and demonstrate good practice but indicates that the issue at hand is whether the amount of support they offer is enough to enable students to apply theory to practice.

She therefore argues that it is legitimate to question whether the mentors have the time, motivation and ability to help the nursing students apply assimilated knowledge to practice and I concur with her.

There is evidence that nurse teachers fail to effectively fulfil their clinical teaching role (Owen 1993; Forrest et al 1996) and this could be attributed to several factors. Previous research reveals a problem of short and erratic clinical visits by nurse teachers (Clifford 1993; Forrest et al 1996). However, Brown et al (2005) indicates that the amount of time spent with students is not quite significant because students can appreciate a visit within a few minutes. Clifford (1993) comments on this questioning what can be achieved during brief clinical visits. Excess workload is also reflected as one of the factors that deter nurse lecturers from fulfilling their role (Crotty 1993; Davies et al 1996; Forrest et al 1996; Grisetti et al 2005; Gillespie and McFetridge 2006; Barret 2007; Meskell et al 2009). Carlisle et al (1997) identified pressure of academic work, lack of time, not viewing the clinical role as a priority and lack of up to date clinical skills as possible causes of the nurse teacher's role failure in a study which was conducted to explore the changing role of the nurse teacher within project 2000. Corlett (2000) identified pressure of workload, feelings of inadequacy and deskilling as factors that hinder link teachers from maintaining their role. Elliot and Wall (2008) indicate that scholarly activities such as research and publication hinder academics from having contact with the clinical environment and maintaining clinical credibility and competence.

Elcigil and Yildirim Sari (2007) examined problems which student nurses in Turkey experience in their work with clinical educators and the following problems were identified: anxiety over evaluation by clinical educators which made students to focus on getting good grades than on learning; feelings of being judged which resulted from detailed questioning; communication problems due to inaccessibility of the clinical instructors; feedback communicated inappropriately; differences between educators; differences between theory and practice; overload and inadequate guidance. These problems portray some of the factors which contribute to role failure among nurse lecturers, more especially where they are directly involved with clinical



teaching as opposed to a liaison role. Other factors responsible for nurse lecturers' role failure include: perceived lack of control over the clinical area and diminished clinical competence (Griscti et al 2005); lack of student-teacher relationship (Lofmark and Wikblad 2001; Gillespie 2002) and the conduct of clinical supervision in a haphazard manner Lewin (2007).

Forrest et al (1996) reveals that nurse teachers have a potential to play an important role in the clinical area despite the role failure. Brown et al (2005) conducted an interpretive phenomenological study which examined the role of the nurse lecturer in practice from the perspective of student nurses and the results revealed that the presence of the lecturer in the clinical environment is quite significant in that it offers support to students. The researchers identified that the roles of the nurse lecturer during clinical placements include directing, motivating and facilitating, problem solving, advocating and troubleshooting and monitoring. They also revealed that when students perceive that lecturers are not guiding nor assessing them, they fall into a non-learning role. Davies et al (1996) identified the following roles of nurse teachers in a study: liaison, troubleshooting, giving support, monitoring progress, keeping staff updated, negotiating placement allocations, participating in student assessment, clarifying the role of practitioners, helping students to achieve objectives and mentoring the mentors. Other roles reflected in literature include organizing learning opportunities and facilitating teaching or learning sessions (Chow and Suen 2001; Koh 2002). Koh (2002) identified the following key benefits of practice based teaching by link teachers; enhanced integration of theory to practice, development of the skill of reflection and increased student and peer support.

A study by Lee et al (2002) concluded that students view maintaining good relationships as the most important characteristic of an effective clinical educator and Student-lecturer relationships are crucial in the promoting clinical learning. Gillespie (2002) conducted a qualitative study which was undertaken to explore and describe undergraduate nursing students' experiences of connection within the student-teacher relationship and the effects of student-teacher connection on students' learning experiences in clinical nursing education. The study findings reveal that

student nurses experience either connected or non-connected student-teacher relationships. Connected relationships focus on personal and professional components whereas non-connected relationships focus only on work and there is no acknowledgement of personal aspects. Student-teacher connection emerged as a strongly positive influence on clinical learning experiences. Gillespie (2005) claims that Knowing, trust, respect and mutuality are inherent qualities of connected student-teacher relationships and this produces an environment which supports students' personal and professional growth. Gillespie therefore asserts that student-teacher connection is a place of possibility.

## **2.8. Student support: role of clinical nursing staff**

Literature indicates that clinical nurses are crucial to students' clinical learning and contribute to their learning experience (Nolan 1998; Jackson and Mannix 2001; Brammer 2006). Similarly, Attack et al (2000) reveal that a greater part of student clinical learning takes place as a result of the interactions which occur between the nurses and the students. Spouse (1998) also claims that support of clinical staff is vital and without it, students find it difficult to learn. However, the role of Clinical nurses in teaching students is poorly explored (Jackson and Mannix 2001). Literature is however replete with studies on the role of mentors in students' clinical learning. Mentors are ideally practising registered nurses who may have undergone some formal preparation for their role of clinical teaching and supervision of students during clinical placements. It is therefore argued that studies exploring the role of the mentors on students' clinical learning would still be significant and can also inform the role of Clinical nursing personnel who are not mentors. My focus is mainly on clinical nurses who support nursing students but not as mentors because nursing education in Malawi does not have an established mentorship system.

Jackson and Mannix (2001) conducted a qualitative study, which explored the role of clinical nursing staff in students' clinical learning from students' perspective. The results of the study revealed that undergraduate nursing students highly value the teaching input of clinical nurses and consider activities such as explaining and questioning to be integral to their learning. The study results also revealed the importance of attitudes and behaviour of clinical nursing staff to the learning experience of students. The results identified helpful and unhelpful interactions which facilitate or hinder students' clinical learning respectively. The most helpful behaviours identified included understanding, being friendly, showing interest and explaining. Unhelpful behaviours included passiveness of the nurses which made the students feel excluded, ignored and disliked. Cheraghi et al (2008) also reflect the importance of attitude of clinical nursing staff towards promotion of clinical learning. The study revealed that there was a less caring attitude towards students by nurses.

Brammer (2006) conducted a study which explored registered nurses' understanding of their clinical role in student learning. The aim of the study was to explore the various ways in which Registered nurses (RNs) understand their informal role with undergraduate nursing students in the clinical environment. The results revealed that RNs understanding of their role can be grouped into four categories and these are as follows; RNs with facilitator and teacher/coach ways of understanding, RNs with peer support and role model and supervisor understanding, RNs who have a controlling approach and RNs with resister/dissenter role. Brammer indicates that the first two approaches promote student clinical learning whereas the controlling approach could lead to limited learning opportunities. The resister/ dissenter role constitute RNs who avoid students therefore students may be left with no one to guide and facilitate their learning. Langan et al (2003) revealed that clinical nursing staff may have positive or negative response to the role of facilitating student learning during clinical experience. The resister/dissenter role is a typical example of a negative response and this commonly occurs when the role expectation is overwhelming to the staff nurse. A study by Papp et al (2003) revealed that negative clinical learning experiences occur when clinical nursing personnel are not interested in mentoring students.

Gray and Smith (2000) conducted a longitudinal study utilising grounded theory approach which was aimed at capturing changes in the students' perspective of their mentors over time. The findings revealed the characteristics of good and bad mentors. Good mentors are knowledgeable, approachable, good role models, confident, good communicators, professional, organised, enthusiastic, friendly, caring, patient, understanding, possess a sense of humour, spend quality time with students, value students contribution to patient care, possess good teaching ability, pace their teaching to match student's needs and incorporate feedback when teaching. Bad mentors lack knowledge, skills, and attitudes of good mentors. I would argue that the same characteristics apply to clinical nursing staff that may not be mentors but are directly involved with clinical teaching.

## **2.9. Student nurses: masters of their own destiny**

Chapple et al (2004) point out that inadequate support is offered to student nurses during their clinical experiences due to nurse lecturers and clinical nurses' failure to fulfil their roles. While this is the case, literature reveals that students themselves have a role in enhancing their own learning from clinical experiences (Papp et al 2003). Baillie (1993) revealed in a study that students' approach to the placement affects their learning and that their interest, initiative and attitude are vital in influencing clinical learning. Students can also be a resource to each other's learning through peer learning which Topping (2005) defines as 'the acquisition of knowledge and skill through active helping and supporting among status equals or matched companions.' Goldsmith et al (2006) assert that peer learning alleviates stress associated with practical assessments by providing student nurses extra opportunities to practice while promoting a positive learning environment. The concept where students learn from each other's experience besides their own primary experience is known as vicarious learning (Roberts 2010). Roberts (2010) reveals that vicarious learning takes place during discourse, discussion, and storytelling where students internalise what is said during the discussion and relate these to their own ideas.

Peer mentoring is also one of the ways in which students can support and facilitate each other's learning during clinical placements and Gilmour et al (2007:37) define it as, 'a mentoring relationship where the mentor and mentee are similar in terms of age and/or status.' Gilmour et al (2007) evaluated the effectiveness of a student mentoring programme in assisting first year students making their transition to the university and nursing. The student mentorship programme was initiated based on students' comments that the first few weeks of the Bachelor of Nursing programme were stressful. The results indicate that the students who contacted their mentors found the mentors information and advice helpful. The mentoring project also promoted collegial interaction and learning amongst the students.

Yates et al (1997) also report findings of a pilot peer mentorship programme which was introduced into a clinical placement for first year students. The programme was developed to promote development of effective clinical learning strategies and to

improve clinical learning outcomes. The findings revealed that the programme was effective in reducing anxiety and increasing confidence. However, no significant difference was observed in terms of clinical performance between the students who participated in the mentorship programme and those who did not. This may be due to complexity of assessing students' clinical learning and the reliability and the validity of the tools used.

## **Conclusion**

In this literature review the experiential learning theory and reflective learning have been substantially discussed. This is in view of the fact that nursing being a practice based discipline, it is required that clinical learning should be underpinned by experiential learning theory. The clinical learning environment (CLE) remains significant for students' clinical practice experience, enabling them to integrate theory to practice, develop nursing practice skills and professional values. The literature review also includes a discussion of various issues which impact on the clinical learning, including roles of the nurse lecturer, clinical nursing staff and student nurses in the promotion of clinical learning. Literature reflects a dichotomy of views regarding the role of nurse lecturers in clinical nursing education. There are authors who support a more clinical orientation; the emphasis being on nurse lecturers maintaining clinical credibility so that they can effectively facilitate clinical learning. Others support an educationalist orientation which requires that nurse lecturers should utilise their educational expertise to support clinical nurses so as to create a positive clinical learning environment. Clinical nurses also significantly contribute to clinical learning but this is a reality where warm and supportive relationships exist between students and clinical nurses and where nurses are willing to engage in a teaching relationship. Students also play a significant role in promoting each other's learning in the clinical setting through the concept known as vicarious learning.

## CHAPTER 3: APPROACH TO THE STUDY

*'No method can be arbitrarily imposed on a phenomenon since that would do great injustice to the integrity of that phenomenon' (Hycner 1985:280)*

### 3.1. 1. Phenomenology

I employed a qualitative approach and this was chosen because of its potential to explore a wide range of issues in relation to the social world and social phenomena (Mason 2002). Qualitative research is committed to investigate the social world from the perspective of the people being studied (Bryman 2004). By virtue of the fact that student nurses are the ones who are directly involved with the clinical learning experience, it was needful to conduct this social inquiry from their perspective. The student nurses are the 'insider' and therefore their accounts provide the 'insider view.' There are several approaches to social inquiry or qualitative research but I chose the phenomenological approach because of its focus on the lived experience. Berger and Luckmann (1967:34) wrote, 'the method best suited to clarify the foundations of knowledge in everyday life is phenomenology.'

Phenomenology is one of the streams of interpretivism (Crotty 1998) and this ensures methodological congruency because this study utilises interpretivism as a theoretical perspective. This implies that the social world is the world interpreted and experienced by its members from the 'inside' (Blaikie 2000). Richards and Morse (2007) reflect that phenomenology is both a philosophy and a research approach. Phenomenological philosophy is intended to guide the researcher to conduct a phenomenological inquiry through its philosophical underpinnings (Fleming et al 2003). Sokolowski (2000) defined phenomenology as the study of human experience and the way phenomena manifest through such experience. The clinical learning experience is a human experience and this justifies the need for a phenomenological inquiry. Van Manen (1990) defined phenomenology as the study of lived existential meanings and Richards and Morse (2007) in support of this view indicate that existence as being in the world is a phenomenological phrase acknowledging that people are in their worlds and this alerts us to the fact that student nurses also occupy their own world. One of the assumptions that underlie phenomenology indicates that perceptions present us with evidence of the world, not as it is thought but lived

(Richards and Morse 2007). Accordingly, student nurses' perceptions of the clinical learning experience reveal the truth about their world.

According to Le Vasseur (2003), phenomenology is well suited for inquiries that focus on meanings derived from experience. A detailed phenomenological analysis enables the researcher to uncover the various 'layers' of the phenomenon being investigated and the meanings involved. Van Manen (1990) states that phenomenology uncovers and describes the internal meaning structures of the lived experience. It elucidates shared meanings of the lived experience and describes what all participants have in common as they experience the phenomenon Creswell (2007) and consistent with this view, the intention of this study was to obtain the student nurses shared meanings of the clinical learning experience.

There are two main approaches to a phenomenological inquiry namely hermeneutic/interpretive phenomenology and transcendental/descriptive phenomenology and in this study I employed hermeneutic phenomenology. History of phenomenology is crucial to the understanding of the origins of the two phenomenological approaches. Phenomenology was a philosophical movement founded by Husserl (1859-1938) and later developed by Heidegger (1889-1976) (Sokolowski 2000). Both Husserl and Heidegger had common interests and shared some similar philosophical elements. For example, they were both concerned with the 'lifeworld' and human experience as it is lived but the two phenomenologists disagreed on how the lived experience should be investigated (Lavery 2003). Husserl's concern was epistemological that is, to provide foundation for knowledge while Heidegger's concern was ontological that is, how interpretation is fundamental to human existence (Todres and wheeler 2001). Husserl's phenomenology is based on Cartesian theory which views the mind as being separate from the body (Bulman 2004). His main focus therefore was the study of phenomena as they appeared through consciousness (Lavery 2003), hence he developed transcendental phenomenology while Heidegger developed hermeneutic phenomenology. Bracketing was one of Husserl's major concepts and this implies suspending prior knowledge so that fresh impressions about phenomena can develop without any interference on the interpretive process (Le Vasseur 2003). Husserl believed that



bracketing would purge the mind of the world and even of the self so as to arrive at the 'transcendental ego' (Le Vasseur 2003). Fleming et al (2003) argue that it would be very difficult, if not impossible to lay aside one's preunderstanding or foreknowledge and I concur with them and it is for this reason that descriptive phenomenology was not used in this study. Reinforcing this view is the recognition that the clinical learning experience being explored in this study is an ontological issue. It has to do with being a student nurse or experience in the 'lifeworld' of a student nurse and this necessarily rendered hermeneutic phenomenology appropriate to guide the study.

### 3.1.2. Hermeneutic phenomenology

The term hermeneutics is derived from a Greek verb 'hermeneuein,' to interpret and the noun 'hermeneia,' interpretation which were derived from Hermes, the wing-footed messenger-god, who was associated with Delphic oracle and was responsible for changing the unknowable to a form that humans could understand via language and writing (Thompson 1990). Geanellos (1998) points out that understanding and interpretation are the primary concerns of hermeneutics and Taylor (1971:3) provides a comprehensive definition of interpretation and he wrote:

Interpretation in the sense relevant to hermeneutics is an attempt to make clear, to make sense of an object of study. This object must, therefore, be a text, or a text analogue, which in some way is confused, incomplete, cloudy, seemingly contradictory – in one way or another, unclear. The interpretation aims to bring to light an underlying coherence or sense.

Taylor's definition reflects an extreme view of how the text to be interpreted might be, which may not always be the case. However, the definition clearly portrays that interpretation involves bringing to light the underlying sense. Phenomenology and hermeneutics are human science approaches which are rooted in philosophy (Van Manen 1990) and sometimes these two terms are used interchangeably in literature. However, Fleming et al (2003) contend that they are not the same and this is the stance taken in this study. I see these two approaches as having a complementary role to each other and to this end; Wilson & Hutchinson (1990) reflects that phenomenology as the study of lived existential meanings focuses on the 'lived experience' whereas hermeneutics has to do with interpretation of the experience. This reflects the two phases which were involved in this study. The first phase involved obtaining accounts of the students 'lived experience' through conversational interviews, verbatim transcription and a thematic analysis of emerging issues. The second was the interpretive phase<sup>11</sup>, where my responsibility was to interpret the accounts which the students gave about their clinical learning experience. This is the main crux of a hermeneutic phenomenological study, the aim being to understand the nature of the experience. Rapport (2005:125) defines hermeneutic phenomenology as, 'the science of interpretation of texts, whereby language, in its written or spoken form, is scrutinized to reveal meaning in phenomena.'

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<sup>11</sup> See the discussion on pages 62-64 on how interpretation was achieved.

Hermeneutic phenomenology promotes textual reflection on the lived experiences and increase ones thoughtfulness (Van Manen 1990). Philosophical hermeneutics focuses on the event of understanding or interpretation as it occurs in the encounter between reader and text (Freeman 2007:926). Lavery (2003) indicates that the aim in a hermeneutic phenomenological study is to illuminate details and the seemingly insignificant aspects within the experience, hence creating meaning and achieving a sense of understanding. Writing from an educational perspective, Van Manen (1990:8) asserts that 'hermeneutic phenomenological research encourages a certain attentive awareness to the details and seemingly trivial dimensions of our everyday educational lives.' The aim of this study was therefore to understand the clinical learning experience for KCN students and to reveal both the details and seemingly insignificant aspects of their experience. Heidegger's and Gadamer's philosophical tenets underpin the study.

### **3.1.3. Heidegger's phenomenology and its application to this study**

Heidegger (1889-1976) is one of existential phenomenologists and his philosophical tenets underpin this study because his beliefs are more deeply phenomenological due to his orientation towards the question of being (Moran 2000). Heidegger's philosophical concepts include; Being-in-the-world, fore-structures, time and space and in this study I only focused on Being-in-the-world and it is the only concept which is discussed. Heidegger believed that 'humans' are always caught up in a world into which they find themselves thrown and this led him to develop the notion of 'In-der-welt-sein' which means 'being-in-the-world' (Moran 2000). Heidegger's phenomenology is directed at understanding 'Dasein' which is translated as 'being,' 'being there,' or 'existence.' This implies that our being is always a being-in-the-world, and therefore our understanding of the world does not come from a consciousness that looks at the world but from our experiences in the world that we must then make sense of (Freeman 2007:927). He believed that understanding of being is contained in 'Dasein's' every day activity and due to such a philosophic orientation; His phenomenology is referred to as phenomenology of 'everydayness' (Cerbone 2006). Heidegger believed that in describing 'Dasein' in their everyday state of being, essential structures which are determinative for the character of its 'Dasein's' can be revealed (Heidegger 1962:38). Describing 'Dasein's' every day activities is a preparatory step that opens the way for interpretation and understanding. Hermeneutic phenomenological inquiry therefore engages the researcher in both descriptive and interpretive activities. In view of this, the participants in this study described their clinical learning experience through narrative accounts and these formed the basis for interpretation and understanding of the clinical learning experience.

According to Heidegger, 'Dasein's' being, is 'being-in-the-world' where, the 'in' does not simply reflect spatial containment but it refers to involvement (Cerbone 2006). Heidegger therefore believed that 'Dasein' is 'world-involved' and 'world disclosing' (Moran 2000). By the same token, student nurses do not just occupy their world; they are involved and interact with it. Heidegger claimed that the goal of phenomenology must be to understand Dasein from within the perspective of a lived experience

(Moran 2000). This reflects the need to understand the 'lifeworld' of student nurses on the basis of their lived experience, which constitutes substantially their clinical learning experience.

Heidegger believed that phenomenology was to be understood based on the Greek word 'phainomenon' meaning, 'that which shows itself in itself' (Moran 2000). He believed that sometimes things present themselves in a 'self-concealing' manner (Moran 2000) implying that things do not manifest themselves fully. His assumption was that the lived experience is veiled and the researcher's responsibility is to unveil the experience in collaboration with the participant (Wilson and Hutchinson 1990). Hermeneutic phenomenology therefore specifically engages with the problem of making the implicit more explicit (Carr 2005). He therefore felt that phenomena cannot be simply described, but rather that phenomenology has to do with seeking of hidden meanings. He felt that the appropriate way of seeking for meaning is the interpretation of text and hence the link between phenomenology and hermeneutics (Moran 2000). He believed that interpretation makes manifest the hidden structures of a phenomenon (Cerbone 2006). In the same way, the clinical learning experience for KCN students was equally veiled and their narrative accounts did not fully reveal the nature of the experience and this is the reason why the students' accounts required interpretation. This enabled me to manifest the hidden structures that inform clinical learning in Malawi and to reveal its details and its seemingly insignificant aspects. In addition, Heidegger believed that our being-in-the-world is manifest and understood through language and speech (Rapport 2005) and this is the reason why I used conversational interviews to obtain students' accounts of the clinical learning experience.

#### **3.1.4. Gadamer's phenomenology and its application to this study**

Gadamer (1900-2002) was taught by Heidegger and he is acknowledged as being central to the development of contemporary hermeneutic philosophy (Pascoe 1996). According to Fleming et al (2003), his main concern was, how is understanding possible? He believed that all understanding is phenomenological and was of the same view as his mentor Heidegger that understanding can only come about through language. He was especially interested in how a bringing forth of awareness of our being occurs in and through language (Freeman 2007). Hence as reflected in Gadamer (2004), he states that Language is the universal medium in which understanding occurs. He viewed language as being uniquely placed and having the potential to reveal meaning and the world. To this end Gadamer (2004:443) wrote, 'but human language must be thought of as a special and unique life process since, in linguistic communication, 'world' is disclosed.' In support of this notion, Holstein and Gubrium (1997) assert that meaning is actively and communicatively assembled in the interview encounter.

Gadamer believed that language, understanding and interpretation are closely linked (Rapport 2005). He believed that understanding can only be possible in the presence of historical awareness which he referred to as prejudice, which Heidegger called fore-conception (Freeman 2007). The concept of prejudice does not carry with it any negative connotations but it is a judgment which is rendered before all the elements that determine a situation have been finally examined (Gadamer 2004:273). He believed that one should have a pre-understanding or foreknowledge or pre-judgments of the phenomenon before one can attain its meaning. Gadamer (2004:291) reflects a hermeneutic rule which states:

We must understand the whole in terms of the detail and the detail in terms of the whole....The anticipation of meaning in which the whole is envisaged becomes actual understanding when the parts that are determined by the whole themselves also determine this whole.

To illustrate this Gadamer states that when learning ancient languages one must interpret a sentence before attempting to understand the linguistic meaning of the individual parts of the sentence. Gadamer (2004:291) indicates that the movement of

understanding is constantly from the whole to the part and back to the whole and that the harmony of all the details with the whole is the criteria for correct understanding and the failure to achieve this harmony means the understanding has failed. Through this, Gadamer portrays understanding as taking place through a circular relationship which he called the hermeneutic circle<sup>12</sup>. Gadamer indicates that the circular movement of understanding runs backward and forward along the text and ceases when the text is perfectly understood. He believed that meaning is achieved through a process of moving dialectically between a background of shared meaning and a more finite focussed experience. He believed that understanding is always an historical, dialectic and linguistic event and is achieved through what he called 'fusion of horizons' (Pascoe 1996). Gadamer (2004:3001) defines the concept of horizon as 'the range of vision that includes everything that can be seen from a particular vantage point.' Turner (2003) points out that the things that are part of our understanding, our view point, which is constantly in the process of formation and being shaped by our past and our awareness of the present, are our horizons. Geanellos (1998a) claims that the only way to reach interpretive understanding is by engaging with text inside the hermeneutic circle and Hekman (1986:111) wrote:

In this interpretive dialogue, between the text and the interpreter, resides the fusions of horizons, which is "a fusion of the text's horizon with that of the interpreter.

Freeman (2007) claims that this involves a critical and reflective process which enables the researcher to create more empowering interpretations. Gadamer emphasises on the need for the interpreter to be guided by 'the things themselves' which requires keeping a fixed gaze on 'the things themselves' throughout all constant distractions that originate in the interpreter himself (Gadamer 2004:269).

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<sup>12</sup> These issues are discussed further under Phenomenological analysis see pages 56-59

### **3.2. Rigour in qualitative research**

Qualitative research is often criticised for lacking scientific rigour (Koch and Harrington 1998) and one of the criticisms is that it is strongly subject to researcher bias and therefore cannot be objective. Several factors hinder objectivity in qualitative research and in the first instance; this has to do with sources of ideas for social inquiry. Weber (1970) asserts that in practice, researchers select certain aspects of the world around them as problematic and worthy of study. Moses and Knutsen (2007) also concur with this view and indicate that the patterns that interest most of the social scientists are out of their own making. The researcher's interest introduces an element of subjectivity at the outset of the study (Weber 1970). Objectivity is also hindered because the 'self' is viewed as a potential contaminant (Finlay 2003). In a qualitative study the researcher is a central figure who actively constructs the collection and interpretation of data and contamination can occur during these stages of the research process (Finlay 2003). Approaching a research project with an open mind is crucial for maintaining objectivity but this is not practically feasible for a phenomenological inquiry. Van Manen (1990:46) illustrates this and he wrote:

The problem of phenomenological enquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much.....the problem is that our "common sense", pre-understandings, our suppositions, assumptions and the existing bodies of scientific knowledge, predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question.

The foregoing issues indicate that some strategies must be put in place in order to promote rigour for a qualitative inquiry. Lietz et al (2006) indicates that rigour within qualitative research involves engaging in efforts that increase the confidence that research findings represent the meanings presented by participants. Lietz et al (2006) indicates that within qualitative research rigour can be achieved in various ways and this implies that there is no standardized way of ensuring rigour and this has been an issue of longstanding debate (Rolfe 2006). Some qualitative researchers believe that rigour can be achieved through reliability and validity whereas Purist qualitative researchers object to utilization of reliability and validity as evaluation strategies



because these are associated with a positivist stance. Koch (1996) asserts that in a qualitative inquiry legitimacy of knowledge claims is dependent upon demonstrating that the research study is trustworthy and I personally concur with this view hence in this study rigour has been achieved through trustworthiness and reflexivity.

### **3.2.1. Trustworthiness**

According to Lincoln and Guba (1985) trustworthiness is established when findings reflect the meanings according to participants' constructions of the phenomena under investigation. Clayton and Thorne (2000) indicate that credibility and confirmability are foundation components of trustworthiness. Lincoln and Guba (1985) proposed strategies to enhance credibility of findings and in this study the following strategies were utilised; persistent observation, peer debriefing, and member checking.

Persistent observation helps the researcher to identify salient issues in relation to the phenomena being investigated and to explore them in detail (Lincoln and Guba 1985). I was able to identify salient issues and to explore them further during subsequent interviews because I personally conducted the interviews. This was also enhanced by doing data collection and analysis concurrently although this was not done to my satisfaction because of the delay in ethical approval.

Peer debriefing is a process of having debriefing sessions with a disinterested peer for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the researcher's mind (Lincoln and Guba 1985). According to Lincoln and Guba, the role of the debriefer is to sensitise the researcher of his or her posture and process and a faculty member from KCN helped with the debriefing sessions. This was a senior faculty member with sufficient experience in qualitative research which made the sessions a success.

Member checking is the most crucial technique of establishing credibility of findings and it involves validating the findings with the participants from whom data was collected (Lincoln and Guba 1985). However, Geanellos (1998a) argues that participant validation of the findings is compatible with the positivist paradigm. In addition, Geanellos (1998a) reflects that in a qualitative inquiry multiple realities or

diversity of interpretations are a possibility therefore it is inevitable that interpretive differences will arise when participants validate the researcher's interpretation of findings. Nevertheless; this does not invalidate the importance of member checking in ensuring credibility of research findings. It should be noted that the researcher in a hermeneutic phenomenological study interprets the participants' narrative accounts of the phenomena being investigated. I would argue that although there are multiple realities, the findings should still embody the 'insider view.' Participants should be able to affirm that the study findings are consistent with their experience. The inclusion of excerpts from students' narratives also enhances the credibility of findings as it portrays that the study findings are representative of the participants' views.

### **3.2.2. Reflexivity**

My position as a researcher was a lecturer exploring the experience of nursing students who happen to have been my own students. I was well acquainted with participants who were drawn from among year four nursing students because I had interacted closely with them when they were in second year during both theory sessions and clinical placements. I was less familiar with participants who were drawn from among third year students because I had not actively interacted with them. The time I left Malawi for my doctoral studies, they were in year one and I remember having taught them once. Nevertheless, whether I was familiar with them or not, the research evolved around the lecturer-student relationship. My main concern during the research was my role and position as a researcher and lecturer. Weber (1970) asserts that in practice, researchers select certain aspects of the world around them as problematic and worthy of study and consistent with this notion, I chose to explore the clinical learning experience because I had perceived it as being a major challenge. The idea to conduct this study stemmed from the passion I had developed for the nursing students. As I interacted with them, more especially in the clinical area, I realised that my passion for them grew stronger. Weber (1970) further asserts that the researcher's interest introduces an element of subjectivity at the outset of the study. The passion I had for the researched meant that if my study

findings will be credible, I should not sympathise with the respondents. This made me conscious of the fact that I should maintain a reflexive stance and to present a 'true' picture of the clinical learning experience. Reflexivity therefore became one of my approaches towards ensuring rigour to enhance the trustworthiness of findings.

Reflexivity is important during research conduct as it helps to promote objectivity and throughout the research process a reflexive stance was maintained. O'Leary (2004) defines reflexivity as the ability of the researcher to stand outside the research process and reflect on the process. However, this definition does not provide much guidance on how to promote reflexivity. Pink (2004) indicates that in maintaining a reflexive stance, the researcher should be aware of how his/her own experiences, knowledge and standpoints inform interpretation of findings as these could be sources of contaminants. Finlay and Gough (2003) assert that reflexivity requires critical self-reflection of the ways in which the researcher's social background, assumptions, position and behaviour impact on the research. Finlay (2003:108) defines reflexivity from a phenomenological perspective as,

A process of continually reflecting upon our interpretations of both our experience and the phenomenon being studied so as to move beyond the partiality of our previous understanding and our investment in particular research outcomes

It is possible to monitor the research process and maintain a reflexive stance through maintenance of a reflective diary (Koch et al 1998; Rolfe 2006). I kept a diary throughout the research process and this was actively utilised during the process of analysis. I documented all the identified themes and all the changes I made and what influenced my thoughts and my feelings.

Geanellos (1998a) reflects that identifying, challenging and qualifying interpreter preunderstanding or foreknowledge is a hermeneutic imperative and this also helps in maintaining a reflexive stance. Gadamer (2004) recommends that this allows the text to manifest its own truth over and against our own preconceived notions. Hertz (1997) claims that reflexivity is accomplished through detachment, internal dialogue and constant scrutiny of 'what I know' and 'how I know.' Through questioning and

internally dialoguing, I was able to maintain a detached stance, so that my position would not pose as a potential contaminant to the findings. My aim was to ensure that my position and interests are not imposed which helps to produce a less distorted account of the social world being explored (Harding 1986).

As already mentioned, I came to know about emotional labour during the period of data analysis, but it substantially influenced how I interpreted my findings. When I read the book titled 'The emotional labour of nursing' (Smith 1992), I was able to identify emotional aspects from the students' accounts. Therefore, initially I identified emotional labour as one of the themes for my findings. However, through questioning myself whether this is what the participants stated, I was able to maintain a reflexive stance which helped to ascertain that the issues emerging were indeed representative of the participants' views and not my own views. Through this I realised that although the students' accounts portrayed emotional labour, they never mentioned it and may not even know emotional labour as a concept. For some time, I struggled and felt very bad that I did not know where to place issues on emotional labour and yet these featured highly in the findings. It was only later that I realised I could utilise emotional labour as a conceptual framework and therefore develop an understanding of the clinical learning experience. I made this decision mainly because of the reflexive stance I took and also because the emotional aspects portrayed by the findings seemed quite salient

### **3.3. Ethical considerations**

Ethical review is important in order to ascertain the safety of research participants. To this effect, the proposal for this study was submitted to various ethics committees for ethical approval. Initially the proposal was submitted to the ethics committee within School of Health at University of Edinburgh. Ethical approval was also sought in Malawi by submitting the proposal to the Ethics Committee at College of Medicine. I also had to seek permission to conduct the study from responsible authorities at KCN where the study took place as this is also an ethical imperative (see Appendix C).

Respect for human dignity is one of the primary ethical principles on which standards of ethical conduct in research are based and this includes the right to self-determination (Polit and Beck (2008). This implies that humans should be treated as autonomous beings capable of controlling their activities. This demanded that prospective study participants should have the right to decide voluntarily to participate in the study without any coercion (Polit and Beck 2008). Informed consent is essential in order to safeguard participants and protect their right to self-determination and this was obtained from the participants prior to data collection (see Appendix B). Informed consent implies that participants have adequate information about the research, and understand the information which enables them to make an informed decision to participate or decline participation. The participants were informed about the following; purpose of the study, type of data, participant selection, procedures and contact information. I obtained both verbal and written consent from all the participants and I also explained the voluntary nature of the consent and the right to withdraw without fear of retribution.

Polit and Beck (2008) reflect that all research with humans involves intrusion into personal lives of participants and participants have the right to expect that the data they provide will be kept in strictest confidence. All audio tapes and notes taken during interviews are kept in a secure place where I am the only person who can access them. Anonymity is the most secure means of protecting confidentiality and this is demonstrated when the researcher cannot link a particular participant with the

information given. This is difficult to achieve for a hermeneutic phenomenological study because the researcher should be able to link each transcript to a participant so as to be able to return the transcript for participant validation. Anonymity was achieved through use of designated speaker identifiers or codes instead of participants' names (see Appendix E). Participants were assured that confidentiality would be observed throughout the study period.

Beneficence is one of the fundamental ethical principles in research which imposes an obligation on researchers to minimise harm and maximise benefits (Polit and Beck 2008). Participants were informed that this study is associated with minimal risks which could be psychological in nature and that any problems occurring would be handled through appropriate counselling. The participants were also informed that the study is beneficial because the results would provide feedback which might form the basis for improving the clinical learning experience. However, it was mentioned that they would not directly experience the benefits because they were nearly completing their studies.

Qualitative research is associated with ethical complexities because of the nature of data collection methods. Conversational interviews utilised in this study are associated with power dynamics and Kvale (2006:485) illustrates this and he wrote:

The research interview is not an open and dominance free dialogue between egalitarian partners. But a specific hierarchical and instrumental form of conversation, where the interviewer sets the stage and scripts in accord with or her research interests.

Sinding and Aronson (2003) also reflect interviewee vulnerability as an ethical concern associated with interviews. They suggest that vulnerability occurs because interviewers are deeply occupied with making meanings that reside within respondents. It is worth mentioning that the power differences are more evident where the researcher and participants have a teacher/student relationship as was the case in this study. However, Kvale (2006) indicates that within education, dialogue is regarded as humanistic as opposed to monologues of authoritarian teachers. Therefore, the conversational interviews played a significant role in creating an

egalitarian partnership between me the researcher and the participating students.

### **3.4. Study setting, population and sample**

The study took place at KCN and the population for the study consisted of pre-registration nursing students and the sample was drawn from among year three and four students. Wilson & Hutchinson (1990) indicate that in hermeneutic phenomenology the sampling is purposive because participants are chosen based on their ability to provide rich descriptions of their experience. The BSc Nursing programme in Malawi runs for four years and year three and four nursing students should be able to articulate their experiences because they have had adequate exposure to clinical learning experience, having gone to various clinical placements as the programme demands. In qualitative research, willingness to share information is significant for successful data collection. In view of this, participants for the study were recruited through volunteering. Although this is associated with volunteer bias, it enabled me to gain more insight into the phenomenon under study as volunteering is an act of co-operation (Parahoo 2006). The sample for the study consisted of thirty participants and the sample size is justifiable for qualitative research because the aim is to discover meaning and to uncover multiple realities as such, generalisation is not a guiding criterion (Burns and Grove 2001). Wilson & Hutchinson (1990) recommend that in a hermeneutic phenomenological study, ten to twenty participants is usually a sufficient sample size.

I did not obtain demographic data on age for the students who participated in the study, but the majority were direct entrants from secondary school so that I was able to estimate their ages as between twenty to twenty-five years, with the exception of one participant who was a mature entrant between age ranges of twenty-five to thirty years. Seventeen participants were females and thirteen were males. Fifteen participants were drawn from each of the two classes where the study sample was obtained from. Table 3.1 below demonstrates the characteristics of the sample and their speaker identifiers which I used for the purpose of ensuring anonymity.

**Table 3.1. Sample Characteristics**

Year 3		Year 4	
Male	Female	Male	Female
St-17-M-3	St-16-F-3	St-3-M-4	St-1-F-4
St-18-M	St-20-F-3	St-4-M-4	St-2-F-4
St-19-M-3	St-21-F-3	St-5-M-4	St-7-F-4
St-25-M-3	St-22-F-3	St-6-M-4	St-8-F-4
St-28-M-3	St-23-F-3	St-11-M-4	St-9-F-4
St-29-M-3	St-24-F-3	St-12-M-4	St-10-F-4
St-30-M-3	St-26-F-3		St-13-F-4
	St-27-F-3		St-14-F-4
			St-15-F-4
Total 7	Total 8	Total 6	Total 9
Total 15		Total 15	
Total Sample 30 – 13 Males & 17 Females			

### 3.5. Access to study participants

After obtaining ethical approval in Malawi, I wrote to the Principal of KCN seeking permission to conduct the study (see Appendix C). As soon as permission was granted, I arranged a meeting with the prospective participants in liaison with the head of the Clinical nursing department because students were currently in their clinical placements. During the meeting, I explained the aims of the study, type of data, procedures and why the group was chosen to be the prospective participants for the study (see information sheet Appendix B). Initially I had planned to have twenty participants, comprising ten third year and ten fourth year students, intending interviewing one participant per day. However, ethical approval in Malawi was delayed such that in the end I was left with less time to conduct the interviews. In view of this, I had to recruit as many participants as I could, as quickly as possible, because the fourth years were completing their studies and it would have been difficult for me to access them after they had left the College. Similarly, the third years were also approaching their Christmas holiday and accessing them during the



holiday would equally have been difficult. Students who volunteered to take part in the study were enlisted as study participants. After recruitment, I was able to come up with a schedule for conducting the interviews and the time for each interview session was scheduled according to the participant's availability. I had purposively chosen third and fourth year students to participate in the study but there were no significant differences between the two cohorts in terms of study findings

### **3.6. Hermeneutic Interviews**

The philosophical view that language is the precondition for understanding rendered dialogue as the appropriate way to obtain descriptions of the student nurse's clinical learning experience. The dialogical approach was appropriate because all knowledge is constructed in social discourse (Berger and Luckmann 1967). Dialogue is conversational in nature and not a question and answer session as normally occurs with ordinary type of interviews (Pollio et al 1997). Fleming et al (2003) reveal that according to Gadamer, the aim of the conversation is to allow immersion into the subject matter and this enables the researcher to gain understanding of the phenomena being investigated. Kvale (2006) reflects that interviews help the researcher to understand the world from the participant's point of view and to unfold the meaning of their lived world. An aide memoir guided the conversational interviews and it was pre-tested as soon as permission to conduct the study was granted.

Conversational interviews were conducted with fourth year students first because they had just come back from their preceptorship experience and they were about to start their final examinations. I had two weeks to conduct the interviews with them and conducting the interviews during the second week was not easy because it was their week of grace to enable them prepare for final examinations. I only had one week to interview the third year students during the initial interviews which took place in the period between 19<sup>th</sup> November and 20<sup>th</sup> December. Twenty-five participants were interviewed initially comprising of fifteen fourth year and ten third year students. In March 2010, I interviewed five more participants after realising that some of the emerging issues were not sufficiently explored, increasing my sample to

thirty participants. These were not necessarily newly recruited, but they were from among the students who had already volunteered to take part in the study during my initial recruitment, but I was not able to interview them initially. They were recruited whilst they were in their third year, but they were now in their fourth but had not had a placement in fourth year. Therefore I still took them as third years because their narratives centred on their experience from year one to year three. On average each interview session took about one hour but some sessions lasted for more than one hour thirty minutes. The interviews were recorded on an audio tape recorder and transcribed verbatim. As Robson (2002) recommended, notes were also taken in case of recording failure. The extract below reflects a typical question which I used to start an interview session and it reads;

I want you to say something about the clinical experiences that you have been having. You have been to different placements, you've had clinical experience in all those different placements, and I would want you to say something about these experiences as clinical learning experiences. What has been your perception of the clinical experiences as learning experiences?

Appendix A reflects the aide memoir which I used during the interviews. This was just a guide and the questions I asked were not as short but they were long. This helped the participant to understand the question and at the same time it helped to initiate a conversation. I allowed the interviewee to talk freely and as much as possible and this was mentioned before commencing the interview. I developed probing questions depending on the issues raised by the participant. I also incorporated understanding gained from previous interviews into subsequent interviews to ensure that the salient issues identified were adequately explored. This was somewhat a departure from the phenomenological approach because it meant asking direct questions.

### **3.7. Limitations of the study**

A few factors pose as limitations for this study and first and foremost, the fact that the study only explored the students' views of the clinical learning experience and did not include clinical nursing staff and nurse lecturers constitutes the main limitation. In addition, the omission of an ethnographic component is also a limitation as this would have provided a better understanding of clinical learning for KCN students with data being collected within the setting in which the clinical learning experience takes place. The passion for KCN students and the passion for clinical learning which prompted me to conduct this study introduced subjectivity into the research process at the outset of the study. In addition recruitment of study participants through volunteering also introduced volunteer bias into the study findings. However, volunteering is an act of co-operation (Parahoo 2006) and this enabled me to obtain rich narrative accounts of the clinical learning experience. Despite the identified limitations I would argue that having paid attention to issues of rigour, the study findings provide valuable insights into clinical learning from an African perspective.

Although qualitative research is criticised for being strongly subject to researcher bias, I would argue that utilisation of such an approach in this study is in no way a limitation. I concur with Hycner (1985:280) who wrote: 'no method can be arbitrarily imposed on a phenomenon since that would do great injustice to the integrity of that phenomenon.' Similarly, Richards and Morse (2007) contend that there is always a best way to do any research project and that a particular method is best suited to a particular problem. The authors further assert that the choice of the best method is driven by the research purpose. The intention of this study was to understand the clinical learning experience and therefore the phenomenological approach was best suited for this. A qualitative approach was employed to ensure methodological congruency, which is a fit between the research question and the method (Richards and Morse 2007).

Qualitative research is also critiqued for utilizing unrepresentative samples so that the study findings cannot be generalized. Lincoln & Guba (1985) argue that

generalization of findings from naturalistic studies is associated with transferability and individual recognition of relevance rather than reductionist concerns such as sample size and measures of control. Therefore, these findings provide significant insights into the clinical learning experience for student nurses at KCN and I would argue that the findings have implications to other countries with similar educational practices. These findings will inform nurse learning in Africa.

### **3.8. Phenomenological analysis**

My initial plan was to utilise Colaizzi's (see Appendix F) procedural steps for phenomenological analysis as reflected in Colaizzi (1978). He is one of the phenomenologists who developed a set of manageable steps and processes which offer a clear structure to the process of phenomenological analysis (Thorne 2000; Strahan and Brown 2005). His procedural steps for phenomenological analysis have been clearly presented and this can reduce the complexity and messiness associated with qualitative data analysis. However, it has some weaknesses and it is in view of this that I had to develop an eclectic framework. Colaizzi's approach to analysis does not reflect the important role that reflection plays in enabling the researcher to develop meaning of the phenomena being investigated. The method involves extracting phrases or sentences that directly pertain to the investigated phenomena but phenomenological analysis goes beyond mere extraction of phrases. The phenomenological researcher deeply engages with texts through reflection and gains insight of the phenomena being investigated (Richards and Morse 2007). Fleming et al (2003) also reveal a problem with Colaizzi's method, stating that the method does not suggest that all understanding is dependent upon preunderstanding.<sup>13</sup> Gadamer greatly upholds the importance of preunderstanding in facilitating understanding of the phenomena being investigated. Therefore recognizing that Gadamer's philosophical tenets underpin this study, this is considered a major weakness with Colaizzi's steps for phenomenological analysis.

Literature also reflects other approaches to phenomenological analysis. For example,

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<sup>13</sup> See discussion on preunderstanding under Gadamer's phenomenology and its application to this study where the words prejudice, prejudgment and preunderstanding are used interchangeably on page 41.

Diekelmann<sup>14</sup> (1992) conducted a phenomenological analysis in which she employed a team approach to data analysis as a way of ensuring rigour. Fleming et al (2003) argues against the team approach to phenomenological analysis because the aim was to control bias rather than to identify the interpreter's biases which facilitated understanding of the phenomena being investigated. In a hermeneutic phenomenological study, bias should not be controlled because it constitutes the interpreter's preunderstanding. The team approach is therefore considered as a weakness of Diekelmann's phenomenological analysis. However, she clearly reflects in her approach to phenomenological analysis how one can arrive at shared meanings and this is important to this study. Giorgi<sup>15</sup> (1985), a psychologist, also developed an approach for phenomenological analysis. However, his approach is grounded in Husserlian phenomenology which upholds bracketing<sup>16</sup> of one's preunderstandings or preconceptions (Fleming et al 2003). This is contrary to Gadamer who views that preunderstanding is central to understanding of phenomena. Therefore, Giorgi's approach to phenomenological analysis is not appropriate for this study. However, I adopted a few steps from his framework for phenomenological analysis.

In view of the foregoing discussion, I developed an eclectic framework to guide data analysis. It was developed with steps which were adopted from Colaizzi (1978), Giorgi (1985) and Diekelmann (1992) and some ideas from Fleming et al (2003) were also useful (see Appendix F for the various approaches to phenomenological analysis). This modification is appropriate because Colaizzi (1978) recommends that his procedural steps can be modified as the researcher considers necessary. The framework I developed for phenomenological analysis consists of a series of steps. Richards and Morse (2007) argue that although the steps give the researcher the idea of how to proceed, the process of phenomenological analysis is not stepwise, nor linear but iterative. Richards and Morse (2007) also reveal that labelling the different elements of the process as steps tends to underestimate the cognitive work involved and distracts the researcher from thinking phenomenologically. Although these sentiments are pertinent, for the novice researcher the steps are quite indispensable

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<sup>14</sup> See Appendix F for Diekelmann's steps for phenomenological analysis

<sup>15</sup> See Appendix F for Giorgi's steps for phenomenological analysis

<sup>16</sup> See page See discussion on bracketing under the section on phenomenology on page 35 -36.

and they make the analysis less overwhelming (Saunders 2003).

Data collection and analysis occurred concurrently initially in order to promote awareness of the emerging issues and identify areas which needed further exploration. This is a requirement for phenomenological analysis (Chambers 1998) and is also important in ensuring data saturation. However, the short duration in which data collection was conducted, a situation which occurred due to a delay in obtaining ethical approval, and also having to do the transcriptions personally hindered the two research processes from taking place concurrently. Data analysis progressed following the step by step approach outlined in the framework for phenomenological analysis (see Appendix F). The interview sessions were followed by verbatim transcriptions which transforms the interview material into a text which the researcher dialogues with (Fleming et al 2003). Lapadat and Lindsay (1999) indicate that transcription is an integral process in the qualitative analysis of language data and contend that transcription conventions employed in a study should be specified. Transcription for this study mainly included the communicative interaction and laughter is the only paralinguistic mark which is reflected in some of the transcripts.

Transcription is not an easy task; Kvale (1996) reveals that attempts at verbatim transcription may produce hybrids of the oral conversation. I experienced two main problems with transcription. Firstly, involvement of other people to assist with transcription proved to be very difficult. I realised that they were missing a lot of words, and because I did the interviews personally, I was able to spot this and it was a great source of frustration because it meant redoing the transcription for the whole interview session. In view of this I decided to do the transcriptions personally in order to have the desired quality of the transcripts. Nevertheless, completion of the transcriptions proved to be problematic because the transcripts tended to be long. On average each transcript was about twenty pages (see Appendix I for sample transcript). Therefore, for some of the interview sessions I spent more time listening and only typed areas which appeared to be reflecting pertinent issues in relation to the clinical learning experience. The second problem was a minor one where in some

cases some recorded words were not quite audible. However in most cases I was able to follow the meaning and the notes taken during the interviews were quite useful. An attempt to get the participants to validate if the transcripts indeed represented what was discussed was also quite difficult but in the end some participants responded.

The fourth step in this analysis required me to read and examine each interview text to identify expressions which reflect the fundamental meaning of the text as a whole. This enabled me to produce summaries of the interview texts. The fifth step involved returning to the interview text reading line by line and extracting phrases or sentences that directly pertain to the clinical learning experience which enabled me to identify salient issues emerging from the narrative accounts. This was a rigorous process of going over every word, phrase, sentence and paragraph in the text in order to elicit the participants' meanings (Hycner 1985). This is a process of getting the essence of the meaning expressed in words, using as much as possible the literal words of the participants. This is an important step which enabled me to stay very close to the literal data or as Gadamer puts it, 'close to the things themselves' and this helped me to identify what Hycner (1985) calls units of general meaning. To facilitate this process I changed my interview texts into table formats with two columns and I pasted phrases or sentences which I extracted from the interview text as units of the general meaning into the column on the right side. Gadamer believed that questioning is an important aspect of the interpretive process as it enables the interpreter to open up to new horizons and hence promotes understanding of the phenomena being investigated. He believed that questioning opens up possibilities of meaning (Gadamer 2004). As I progressed reading line by line, I asked myself what is beneath each expression and the notes I made in the margins were quite useful in guiding me which other interview text to read.

During data analysis I realised that although I had formulated a framework for phenomenological analysis, the steps were not as definitive in guiding the identification of themes and this prompted me to read on thematic analysis. Ryan and Bernard (2003) reflect that at the heart of qualitative analysis lies the task of

identifying themes. Their approach assisted me to identify the emerging themes for my study. These approaches include a careful scrutiny of the texts and word based techniques such as word repetitions. Ryan and Bernard reveal that words that are repeated are often seen as being salient in the minds of respondents. For example, the expression 'we cover shortage' was commonly mentioned among the students and this is how I identified it as one of the themes. Paving was also used where quotes which reflect meaning were marked with a different font colour. Some cutting and sorting was also done as a formal way of paving through the computer function of cutting and pasting. Using these strategies and also through persistent reflection on the extracted phrases, sentences and paragraphs I was able to make meaning of the data which also enabled me to identify emerging patterns and themes for my study. Through comparing and contrasting the texts I was able to identify commonalities among the participants and these constitute the shared experiences. Aronson (1994) indicates that the emerging themes are pieced together to form a comprehensive picture of the collective experience for the participants and it is through this process that I was able to understand the clinical learning experience for KCN students.

I identified four constitutive patterns from the data purely on the basis of what the students narrated. According to Diekelmann (1992) a constitutive pattern expresses the relationship among themes and this illustrates that the themes under each constitutive pattern share some commonality. The constitutive patterns include: clinical learning in Malawi: problems and challenges; experiencing clinical learning; student related factors in clinical learning and the nature of the clinical experience. The constitutive patterns and the identified themes are discussed in Chapters' four to seven and the themes under each constitutive pattern are presented in Table 3.2.



**Table 3.2: Constitutive patterns & Themes**

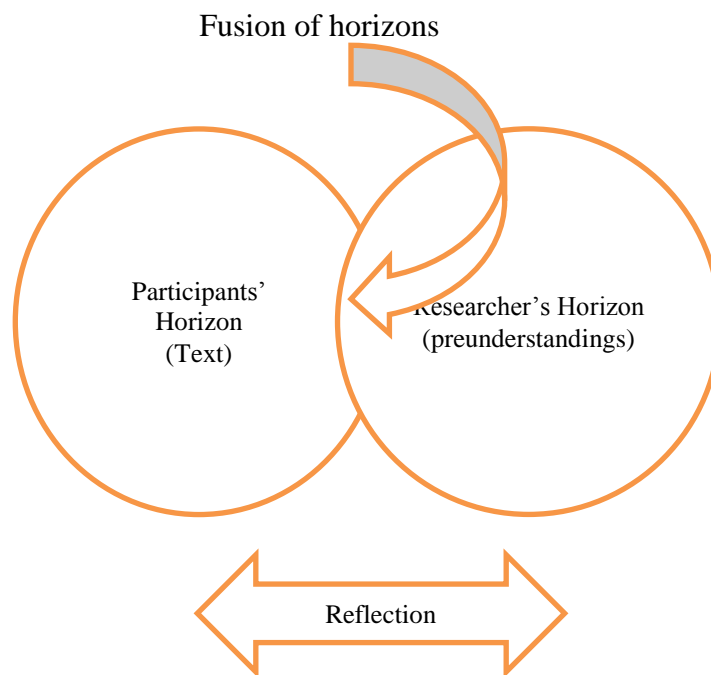
	Constitutive Patterns	THEMES				
Chapter 4	Clinical learning in Malawi: problems & challenges	'We cover shortage'	'Learning in a hard way'	'Lost sheep'	Biased clinical assessments	Stressful experiences
Chapter 5	Experiencing clinical learning	Learning to become a nurse	Student support: encounters with lecturers	Student support: encounters with clinical staff		
Chapter 6	Student related factors in clinical learning	Student motivation	Peer support and shared learning	Student attributes		
Chapter 7	The nature of the clinical experience	Taking care of patients	Encounters with HIV positive patients	Running errands		
Chapter 8	Voices of Malawian undergraduate student nurses: exposing emotion work (Discussion chapter)					

The four constitutive patterns identified in this study make up the findings chapters. The results depict the problems and challenges which students encounter during their clinical learning experience and these are discussed in Chapter four. In Chapter five the results portray what students learn, how they learn and the nature of support attainable during the clinical learning experience. The chapter also depicts a series of learning trajectories for the nursing students. Chapter six reveals how student related factors for example, student motivation, personal attributes, peer support and shared learning impact on clinical learning. Both intrinsic and extrinsic motivation are significant but the former is the main determinant of clinical learning. Chapter seven reflects the students' main preoccupation during their clinical placements. The study reveals that they spend most of their time caring for children and adults with medical-surgical conditions. The chapter also presents issues which are pertinent in the care of patients with HIV/AIDS.

However, the identification of the constitutive patterns and the themes did not mark the end of the analysis. The role of a researcher in a hermeneutic phenomenological study is to interpret participants' narrative accounts in order to understand the phenomenon being investigated. Heidegger (1962) claims that phenomena always manifest themselves in a self-concealing manner and interpretation makes manifest the hidden structures of the experience being investigated. Gadamer (2004:291) asserts that understanding is achieved through the hermeneutic circle and the hermeneutic rule indicates that 'we must understand the whole in terms of the detail and the detail in terms of the whole.' This is a critical and reflective process (Freeman 2007) and involved moving from the texts, which reflect the participants' horizon or perspective, to my horizon, which largely constitutes my preunderstandings of the clinical learning experience. My preunderstandings of clinical learning stem from my personal experience and knowledge. Gadamer further asserts that understanding occurs through fusion of horizons and Koch (1996) gives a clear picture of what this might mean by stating that in a hermeneutic inquiry, data generated by the participant is fused with the experience of the researcher and placed in context.

I designed Figure 3.1 below which portrays how I envisage occurrence of understanding within the hermeneutic circle. When I first began my study, I did not have any knowledge of the emotions literature and in particular the emotional labour of nursing (Smith 1992). However I acquired this knowledge in the process of analysing my data and it greatly influenced how I interpreted my study findings. Therefore, I used emotional labour (Hochschild 1983) as a basis for my preunderstandings and interpreted the students' accounts of their clinical learning experience against such a conceptual framework. As I read through the texts, what resonated was the emotion work which students engage in due to the emotionally charged situations which confront them. Basing on the hermeneutic rule that 'we must understand the whole in terms of the detail and the detail in terms of the whole,' I would argue that as a whole, clinical learning is an experience suffused with emotions and emotional labour is inevitable.

**Figure 3.1: The Hermeneutic Circle**



Gadamer (2004) claims that language is 'world disclosing' and consistent with this view, I would argue that the students' language portray the reality about their world. There is evidence of severe nursing shortage and gross lack of supplies in the clinical settings where students gain their clinical practice experience. In addition, there are relational problems between the clinical nurses and the student nurses, which seem to be linked to the fact that KCN students are pursuing a Bachelor's degree. Furthermore, student- lecturer interactions in the clinical area are sometimes characterised by 'shaming practices'<sup>17</sup> (Bond 2009). All these factors affect students emotionally and their accounts reflect evidence of emotion regulation and management in response to the emotionally charged situations which confront them. These findings support the assertion by Froggatt (1998) that language is a signifier of hidden meanings about implicit aspects of emotions. I now proceed to present my findings related to clinical learning and the emotional issues which emerged are discussed in Chapter 8.

<sup>17</sup> See discussion under the theme 'Emotional labour in caring-learning relationships' on pages 213

## CHAPTER 4: CLINICAL LEARNING IN MALAWI: PROBLEMS AND CHALLENGES

*Without practice placements of the highest quality even the most innovative curriculum will fall on stony ground. (Birchenall 2001:250)*

The study reveals that KCN students encounter enormous challenges during the clinical learning experience. This is due to problems prevalent in the clinical settings where students gain their nursing practice experience. The problems include severe shortage of nurses, gross lack of material resources, unwillingness to teach students and negative attitudes which some clinical nurses<sup>18</sup> exhibit towards KCN students. Nursing shortage is rampant in Malawi and the statement, 'we cover shortage' was a constant theme during the interview sessions. Students also mentioned that they 'learn in a hard way' and this is mainly due to lack of material resources and other factors which also cause students to 'learn in a hard way' include lack of support from qualified nurses and 'policing' approaches of clinical supervision<sup>19</sup> which some of the lecturers employ. The study illustrates that there is inadequate support with clinical learning from nurse lecturers. Consequently, students are left in the clinical settings unsupervised and the learning that takes place is substantially self-initiated. This is eloquently captured by the expression 'lost sheep' which was coined by one of the students. Assessment of students' clinical competence is another challenging issue. The study reveals that clinical assessments are significantly influenced by relationships between students and ward sisters.<sup>20</sup> Students therefore perceive that the assessments are biased and that sometimes they do not reflect a student's true performance. Stressful clinical learning encounters are also common. Therefore, the themes that emerge include 'we cover shortage'<sup>21</sup>, 'learning in a hard way'<sup>22</sup>, 'lost sheep'<sup>23</sup>, 'biased clinical assessments'<sup>24</sup>, and stressful experiences.

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<sup>18</sup> The word clinical nurse refers to any nurse working in the hospitals regardless of whether they are registered (RNs) or enrolled/nurse technician and the word is used interchangeably with qualified nurses or nurses or clinical nursing personnel or clinical nursing staff. It is used commonly when mentioning nurses other than ward sisters/in-charges

<sup>19</sup> Clinical supervision refers to visits to the clinical area by nurse lectures aimed at facilitating clinical learning and the study reveals variation of approaches

<sup>20</sup> Ward sister refers to a senior clinical nurse who is responsible for ward administration and clinical teaching and is used interchangeably with the word ward-in charge

<sup>21</sup> Identified as a theme because it is a common expression which students made and it clearly reflects the meanings they make of their clinical learning experience

#### **4.1. 'We cover shortage'**

Students reiterated that qualified nurses perceive their presence in the clinical area as a way of covering up the nursing shortage which is quite rampant in most clinical settings in Malawi. The vacancy rate for nurses is at 74% (WHO2011) and this confirms that there is severe nursing shortage in Malawi. Some of the students expressed the following sentiments:

In most of the hospitals when students go on a clinical allocation, they take that as a replacement for shortage (St-5-M-4)

From the general experience when we are in the ward we are like there to cover shortage. (St-21-F-3)

There is so much reliance on student nurses regardless of their level in the programme such that even year one students are taken as if they are capable of working and contributing significantly to patient care. Students bear the burden of caring for patients and work tirelessly during clinical placements. Sometimes they take full control of patient care without which most patients are left unattended. These findings have resonance with the assertion by Holland (2002) who argues that student nurses appear to be central to the well-being of patients and that they make a significant contribution to patient care and service delivery. Literature on the traditional British nursing education system reflects such a reliance on students (Fretwell 1982; Melia 1987; Smith 1992; O'Driscoll et al 2010). This was an apprenticeship model<sup>25</sup> of nursing education and this was expected because under such a system students had an employment contract with the local health board (Ferguson and Cerinus 1996; Begley and Brady 2002).

Nurses perceive the students' presence on the wards as a time when they can have respite. Most of them do not work alongside the students but they simply seat in the nurses' station and delegate work to students. The study reveals that this makes the

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<sup>22</sup> The category 'Learning in a hard way' was not commonly mentioned but reflects a synthesis of their expressed sentiments

<sup>23</sup> The theme 'lost sheep' was mentioned by one student but it perfectly conveys a picture of being left alone which was commonly mentioned by the students and this is presumably derived from the parable of the lost sheep in the Bible reflected in Mathew 18:12-14 and Luke 15:3-7

<sup>24</sup> Identified as a theme because it reflects a major concern of the students

<sup>25</sup> This was the traditional hospital based nurse training where training was mostly on the job with very minimal instruction and the students were counted as part of the hospital staff.

students feel like they are not actually learning but working and some of the students described it this way:

And again I had to cover up the shortage that was there in the wards so I had to do like two things at a time; achieving my objectives and covering up the shortage .(St-2-F-4)

The clinical setting as a learning environment to some point is not ok because it feels like we are not actually learning but we are actually working. (St-3-M-4)

Other studies reflected in literature also touch on similar themes (Polifroni et al 1995; Shen and Spouse 2007) and this reveals that even with university based nursing education, just like with the apprenticeship model; the problem of nursing students appearing to be working as opposed to learning still remains unresolved. These findings also lend support to the assertion by Johnson and Preston (2001) that in busy clinical settings students are often seen as an extra pair of hands and not as learners. Napthine (1996) interprets this as exploitation of students and I would argue that in most clinical settings in Malawi students can easily be exploited by being taken as an extra pair of hands because of the rampant nursing shortage. This negatively impacts on students' clinical learning and students complained of failing to achieve their learning outcomes because they concentrate on meeting patients' care needs rather than paying attention to their own learning needs. One of the students had this to say:

I see that whenever students go to the clinical areas the staff tend to relax, they think it is now time that the students should come and work. They don't actually take the students as coming to learn but coming to work (.) they leave a lot of work for us students. (.) We have to care for a lot of patients do a lot of work in the ward and we actually learn little (.) When you see different patients suffering (.) you want to help them first before you complete your specific objectives. (.) So I tend to shift my objectives to the second day and it goes on like that (St-26-F-3)

KCN students care for a lot of patients during their clinical placements which increases their workload and makes them to overwork. They complained that they feel fatigued at the end of the day which affects their ability to study. Several factors contribute to this, but largely it is a consequence of the severe nursing shortage. KCN students are also compelled to overwork because qualified nurses are the ones who

evaluate them and they need to comply with whatever the nurses tell them to do, as failure to do so would have negative implications on the grade they will get at the end of the clinical placement. These issues are further illustrated in the following excerpts:

There is really a high workload yah, (.).You have so many patients (.). Instead of doing total nursing care, you are trying to help each and every patient and then at the end you miss out to help other patients because there are just too many of them. And then you are just a student you just have to do whatever the nurses wants you to do. (.) So you are forced to do so many things because every patient needs to be cared for; so the workload is really too much. (St-15-F-4)

When we are in the wards, the nurses think we are there to cover the shortage. They would leave everything on us and when knocking off at five pm you end up being very tired because you have worked a lot. There are a lot of routine works that we are supposed to do. They would say you are a student you are not supposed to sit down, you are supposed to be doing everything in the ward, and we are the ones who are going to sign your competences<sup>26</sup> so you force yourself even if you are tired. So if they just sit down and if you think for the betterment of the patient you go and do it. (St-23-F-3)

These findings are in agreement with Brammer (2006) who reveals variations in the way registered nurses understand their role in student learning and these range from a focus on the student as a future peer, to a focus on completion of workload. Some RNs are authoritative and tend to exercise control over students and some have a preference for no contact with students. The findings in this present study considerably reflect a focus on completion of workload and there is also evidence of preference for no contact<sup>27</sup> with students.

Students also overwork in order to alleviate patients' suffering. They would rather forfeit their learning than see patients suffer unattended because they want to meet their learning needs. Solvoll and Heggen (2010) portray Norwegian nursing students being moved with the suffering of patients in a study which explored opportunities

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<sup>26</sup> The excerpt portrays how assessment issues impact on the clinical learning experience. This is discussed in chapter 8 under the theme 'Emotional labour during caring-learning relationships.' See discussion on pages 196 -199.

<sup>27</sup> Nurses preference for no contact with students is discussed under the theme 'Student support: encounters with clinical staff' See discussion on pages 124 – 126.

and limitations which nursing students encounter during their practice placements. Solvoll and Heggen conclude that there is a potential for care in today's students and this is consistent with the findings in this present study.

Some of the studies reflected in literature also confirm the problem of high workload and exhaustion among nursing students (Mashaba 1994; Lee and French 1997; Lindop 1999; Shen and Spouse 2007). Spouse (2000) reflects divergent findings in that the students who participated in her study were relieved from the burden of workloads due to their supernumerary status. This occurred following changes within British nursing education for example, the introduction of supernumerary status in 1990s, which involved removing students from the clinical rosters (Elcock et al 2007). Prior to this UK student nurses combined the roles of the learner and primary care giver (Fretwell 1982; Melia 1987; Smith 1992; O'Driscoll 2010). However, KCN students equally have a full student status but it appears this does not keep them away from the heavy workload. This difference could be attributed to variations which occur from country to country because of the way nursing education is managed and also depending on the magnitude of nursing shortage. In common with existing literature (Fretwell 1982; Melia 1987; O'Driscoll et al 2010), the study reveals that the high workload interferes with student learning.



#### **4.2. 'Learning in a hard way'**

Three main factors are responsible for the difficulties which students experience during clinical learning encounters and these include firstly, gross lack of supplies, Secondly<sup>28</sup>, the unwillingness to teach and negative attitudes displayed by some clinical nurses and thirdly, the 'policing' approach of clinical supervision which some lecturers employ.

Government hospitals namely, Central hospitals, constitute the main teaching hospitals for KCN and other health care educational institutions in Malawi. These are referral hospitals and they provide specialist or tertiary care to patients from different parts of the country. However, most government hospitals lack essential supplies. Consequently, students improvise in order to perform various nursing procedures. This frustrates and demotivates them and hinders their learning and some of the students had this to say:

I would just say it makes the learning so hard, we learn in a hard way but still more if you have this to say I want to learn, you still learn. (St-20-F-3)

You work hard when you have resources and sometimes you get frustrated when you don't have resources. You are always improvising (.) and the whole learning process is not facilitated (St-5-M-4)

Most of the times we are allocated into government hospitals, the materials that are there usually are not enough; they cannot facilitate your learning. Most of the times we are improvising and we don't do the ideal things (.) So it really affected my learning. (St-9-F-4)

The Malawi project (2010), a humanitarian aid organization in Malawi, also confirms that shortage of supplies is overwhelming even at referral hospitals in Malawi. Students therefore frequently perform nursing procedures utilising improvised equipment and the repeated exposure to such nursing practice results in students becoming habituated to them so that even when they find themselves in settings with adequate equipment they always revert to what they are accustomed to.

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<sup>28</sup> Problems arising due to interactions with clinical nurses and nurse lecturers are discussed in chapter 5

Mashaba (1994) revealed similar findings in a study which explored the status of students undertaking basic nursing courses in South African institutions and the participants in her study indicated that equipment were poor which hindered development of competence with clinical procedures. Kapborg (2000) also reflects lack of material resources in a study which explored how Lithuanian nursing students perceive their pre-registration training.

This present study reveals issues that centre on the theory practice gap<sup>29</sup>. The students I interviewed reiterated that in class they are taught the ideal nursing but they encounter something different during clinical placements due to lack of resources. The difference between the ideal nursing practice and what is actually happening on the ground is evident and some of the students had this to say:

The only problem is when you are in class you learn something that is ideal but when you go to the wards; you find that it's a matter of improvising (.) if we say we are here to practice what we indeed learnt in class definitely there is nothing that you can achieve by the end of the day. (St-30-M-3)

It's been quite an experience to go to the hospitals but then at times we could feel like it's very different from what we learn in class because in class we learn the ideal things and at the ward we learn something. (St-3-M-4)

Literature illustrates that the theory practice gap is a major problem in nursing education. Students commonly perceive a difference between how nursing is taught and how it is practiced in the clinical setting. There is evidence that what is taught in class constitutes an idealised version of nursing which is contrary to the realities of practice and the following studies support this claim (Melia 1987; Lee and French 1997; Nylund and Lindholm 1999; Corlett 2000; Kapborg 2000; Shin 2000; Kyrkjebø and Hage 2005; Sharif and Masoumi 2005).

The lack of material resources also influences how students perceive the CLE. Generally, KCN students perceive their CLE as not conducive for learning and some of the students expressed the following sentiments:

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<sup>29</sup> The theory practice gap is discussed further in chapter 8, see discussion on page 168 -169

There are no resources, you have to improvise everything. So it was like the setting was not quite conducive for the clinical learning experience. (St-2-F-4)

Most of the clinical settings are not suitable for students' learning because most of the times the resources are limited. So it becomes difficult for the students to learn the ideal nursing. (St-14-F-4)

These results support findings of previous research which also report non-conducive clinical learning environments (Hart and Rotem 1994; Lee and French 1997; Cheraghi et al 2008).

Kachiwala (2007) explored clinical learning among nurse technicians<sup>30</sup> at Malamulo Nursing College in Malawi. Her study reflects contrasting findings in that the students who participated in her study regarded the wards as good learning environments. Kachiwala also revealed a positive ward atmosphere for student learning and positive attitudes among clinical nurses towards clinical supervision. The difference in the findings could be attributed to the fact that Kachiwala conducted her study at a mission hospital<sup>31</sup> and this implies that the CLE at a mission hospital is not comparable to the CLE within government hospitals. This present study also confirms this and one of the students I interviewed expressed the following sentiments:

In the mission hospital the resources were available so it was easy to learn yah because you practice the ideal. (.) The staff are friendly<sup>32</sup> and you can work with them without having any problems (.) they were willing to teach.(.) throughout my eight weeks experience I didn't have any problems with the staff but if you are in a government hospital even the ward you are allocated to you have problems with the staff.(St-9-F-4)

This study also reveals that some private hospitals in Malawi are quite conducive for

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<sup>30</sup> Nurse technician are a cadre of nurses lower to registered nurses. This is a term which is being used presently in Malawi instead of enrolled nurse

<sup>31</sup> A mission hospital is a health care facility affiliated to a church and these hospitals are under the jurisdiction of Christian Health Association of Malawi (CHAM) as discussed in chapter one under Nursing education in Malawi on page 8. These are hospitals which were established by missionaries and such hospitals have adequate resources compared to government hospitals. Most of the mission hospitals are also linked to a nursing college and it is these training institutions which have been instrumental in the production of enrolled nurses in Malawi and presently they are training nurse/midwifery technicians.

<sup>32</sup> The excerpt portrays issues on student-nurse relationships and these issues are discussed in chapter five on pages 126 -127 and also in chapter eight on pages 199 - 201

students' clinical learning. Students who have had a placement at a private hospital<sup>33</sup> or mission hospital reported of having learnt the ideal nursing practice during the experience because of adequate resources and also because the staff were friendly and willing to teach. In addition, exchange visits<sup>34</sup> abroad have also been helpful in enabling students to learn ideal nursing for students who had such a privilege. The following voices illustrate these issues:

For the preceptorship period I was at (Private hospital) that's where I really learnt that maybe this is what is supposed to be done in nursing. (.) I thought it was a very good setting for clinical learning. (.) The staff were very willing to teach. (.) And the resources were there; (St-2-F-4)

I can say the exchange programme is good because I really practiced the real nursing (.) the hospital where I was almost everything is there (.) I have learnt a lot and it's very good in improving our clinical experience. (.) I had a chance to go to a nursing home I practised there for a month (St-14-F-4)

The study also reveals that in government hospitals some ward settings also enable students to learn ideal nursing and this is true for paying wards and intensive care (ICU) and high dependency units (HDU). In such settings the resources are adequate, the nurses supervise students adequately and there are fewer patients compared to the general wards where there is normally congestion of patients. The following excerpts confirm this:

I benefited more when I was in first year (.) at a paying ward (.) Everything (*material resources*)<sup>35</sup> that we are supposed to make use (.) were available (.) the qualified nurses were at our side assisting us as a result we learnt a lot (St-30-M-3)

In most Intensive cares we have four patients. So it's a manageable number despite the fact that they need more care yah, (.) most of the resources we lack in these general wards you find in Intensive care they are there. (St-8-F-4)

Conversely, the study findings also point out that although government hospitals lack

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<sup>33</sup> A private hospital is not government owned and such hospitals are fee paying hospitals and have adequate clinical nursing staff and material resources.

<sup>34</sup> Kamuzu College of nursing has link relationships with some institutions of higher learning in some western countries and this partnership involves exchange visits for both faculty members and students and a few students have been beneficiaries of this programme.

<sup>35</sup> I included the word material resources to promote clarity of the sentence

material resources other factors in such hospitals promote students' learning. Central hospitals offer good learning opportunities because students are exposed to more disease conditions from which they can learn. Secondly most of the clinical staff such as doctors are willing to teach students. Some students felt that the nursing shortage allows them to have more time for practice and hence promotes their learning. One of the students had this to say:

Ah frankly speaking the clinical setting is very good (.) because in Malawi there is a situation whereby nurses are very few (.) patients depend on us and we have more time to practice. Central hospitals (.) are big referral hospitals where we are attached. (.) So we have the opportunity to see most of the rare procedures, most of the rare conditions and we are able to manage these clients. (St-4-M-4)

This reflects satisfaction with the learning opportunities in the CLE. Dunn and Hansford (1997) claim that student satisfaction with the CLE may be linked to positive learning experiences and consistent with this view, my study reflects students' satisfaction with the CLE which is associated with their ability to encounter the various conditions they learnt in class which enhances their learning.

### 4.3. 'Lost sheep'

Students' narratives largely reflect that most of the times they are left alone in the clinical area without being supervised by nurse lecturers<sup>36</sup> and this is well illustrated by the phrase 'lost sheep,' which was mentioned by one of the students as she gave account of her experience and she had this to say:

Students from College of Medicine, it is really nice they are with supervisors during all clinical allocations (.) They work together but we are like lost sheep, we don't have supervisors, yah we work alone. (St-21-F-3)

This reveals that there is inadequate clinical supervision and in some cases this causes feelings of isolation or abandonment and this is consistent with previous research (Simukonda and Rappsilber 1989; Green and Holloway 1997; Shin 2000; Koh 2002; Kachiwala 2007). Students reported that due to lack of support, the learning that takes place is essentially self-initiated and that sometimes they learn through trial and error. Some of the students had this to say:

So we learn from our own experience. Those who have a heart of learning they will learn but those who need someone to be there its quite difficult but still more we learn. (St-21-F-3)<sup>37</sup>

I don't think the lecturers are doing their job to the maximum (.) we learn on our own like sometimes by trial and error yah. (St-25-M-3)

These findings illustrate that clinical learning for KCN students is mainly unguided and this replicates findings in previous research (Polifroni et al 1995; Lee and French (1997). Clinical nurses are equally not available to support students and some of them have a general feeling that KCN students are capable of working on their own without supervision and the following excerpts confirm this:

They feel that we are nurses especially from KCN; we can do anything that other nursing schools cannot do. And then they don't understand it's the first time for us to be in the hospital. (.) Sometimes it's ok sometimes it's not because you can make so many mistakes which cannot be good for patients.

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<sup>36</sup> Nurse lecturer refers to an individual employed by KCN as an educational institution whose role includes both theoretical and clinical teaching and the term is used interchangeably with lecturer and clinical supervisor

<sup>37</sup> The statement, 'those who have a heart of learning they will learn' reveals the students' resilience and a few other students expressed similar sentiments and I have discussed this in chapter eight on page 171

(St-15-F-4)

Most of the clinical nurses take us students as we have learnt everything, (.) Therefore they say we are people who can deliver everything even without assistance. That is a hindrance to our learning in the clinical area (St-30-M-3)

Spouse (2001) asserts that without the support of an assigned mentor, the student experiences difficulty and has to 'muddle' through on her own and it appears this is typically what happens to KCN students. Some of the accounts which students gave confirm that they sometimes take care of patients without being supervised and the students had this to say:

What I have seen is that when students go on a clinical allocation, they take that as a replacement for shortage of staff. And instead of you working with senior nurses to direct you as maybe lecturers would do when they come to the ward, you would see that they are leaving you alone to do nursing work. And there are times whereby you don't know what you are supposed to do, there is no senior, you are alone as a student and you are stuck and very unfortunate when a mistake happens they will never say you are a student. (St-5-M-4)

It should be year two, and being on night duty as students, we really wanted supervision because we had not mastered much of the things by then. But then what we found is that the Sisters would go to sleep and they would say when you have problems just deal with those problems we are sleeping don't disturb us. So you would find it's somebody's life and you don't know how to handle the problem (.) That was so stressful to us, what if something happens to the patient? We will be responsible and yet we are not supposed to work alone, we are supposed to work under supervision. So to us it was a challenge but we forced ourselves even when we had a problem we would wake the Sister, she would shout at us but eventually she would assist. (St-8-F-4)

I remember one time I was at (name of hospital) so we were two of us on night duty. The other one was an enrolled nurse so she was on locum. She had worked during the day and she worked during the day and she was also supposed to continue the following day. So this nurse left at around 5:00 am and left me alone in the ward. So I administered the drugs, I did everything, then this other patient came and reported to me that I should go and see another patient. So as I went there I found this patient restless he had anaemia (.) So as a student it was like what should I do to save this patient? I am all alone what should I do? (St-9-F-4)

Consequences of leaving students unsupervised are quite evident from the study findings. Students perform procedures which are beyond their competence and sometimes mistakes do occur and the excerpt below reflects an experience of one of the students when she was in year one.

In year one I had an experience that I will never forget (.) I was in a surgical ward and there was a client who needed a catheter because that client had paralysis (.). So a certain fourth year student (.) told me let's go I will be observing you and you are going to insert the catheter. So with that eagerness I went (.) and I inserted the catheter. After inserting it (.) there was no urine that came out. So I asked my senior should I insert it more and the senior said ah no (.) So I inflated the balloon. I went around that was after break time, I checked there was nothing in the bag. Then I went again to that student and told her that there was nothing in the bag maybe something is wrong but that person was just comfortable eh saying nothing is wrong just be cool, it happens (.). At twelve I went for lunch, I was failing to eat; I was just thinking eh maybe something is happening to the client, what if the patient dies (.). At 1:00 o'clock I found that there was no urine so I said lets go and remove that catheter I am feeling uncomfortable; I feel something has happened. Then we went (.) we removed the catheter eh and the blood that came out! Blood, clots of blood all those things eh! (St-10-F-4)

Such errors occur because students are left unsupervised and sometimes they learn through trial and error. As the extract reveals year one students are very eager and excited to perform almost every procedure and this is why mistakes are likely to happen when they are not being monitored. It also appears that leaving students unsupervised grossly affects their skills acquisition, no wonder the senior student also demonstrates skills deficit which is evidenced by her lack of knowledge that urine drainage confirms successful insertion of a catheter.

The above excerpt also portrays the distress which students experience as they fear that a patient might die due to their actions. Furthermore, the study illustrates that leaving nursing students unsupervised puts patients' lives at risk and this raises the issue of patient safety within learning and caring encounters. Probably there are no statistics in Malawi on adverse effects which cause harm to patients but statistics from the National Health Service (NHS) in the UK reflect that harm to patients is estimated to occur in 10% of the admissions (DoH 2000). This means adverse events pose considerable risk to patient safety. I believe that the risk to patients might even



be high in Malawi due to severe nursing shortage and gross lack of material resources and leaving students unsupervised also contributes to this risk. This explains why some patients openly refuse<sup>38</sup> to be taken care of by students which some of the students alluded to. All in all, the findings reflect a situation which (O'Driscoll et al 2010) refers to as a deficit in leadership of practice learning because students mostly lack guidance with clinical learning.

Students respond to lack of supervision differently; for some students this helps them to gain independence while for others they take it as a time when they can relax and some even abscond from the clinical area which leads to non-learning. Some of the students gave the following accounts:

when we were like in Mzuzu the level of supervision was very minimal because we were most of the times alone so I think it wasn't good, it was good because we were learning to be independent but it wasn't good because some of the students tend to relax when the supervisors are not there so that wasn't good. (St-23-F-3)

While in Mzuzu<sup>39</sup> (.) lecturers actually come from Lilongwe so supervision is very poor. So students tend to get out of the mood<sup>40</sup>, as in students would sort of relax as a result you would abscond of course from the wards (.) (.) Learning would not take place as there would be no reinforcers St-28-M-3)

The relaxation and abscondment that ensues confirms the assertion by Brown et al (2005) that when students perceive that nurse lecturers are not guiding nor assessing them they fall into a non-learning role. This clearly reflects the need for student support during clinical placements. Parker et al (1993) posited that not many students would be able to benefit from the potential critical learning incidents that nursing education provides unaided. Similarly, Birchenall (2001:249) asserts that 'facilitation is an essential component of learning through practice and without it; students become aimless in their endeavours to glean anything worthwhile from their

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<sup>38</sup> See discussion under the theme 'Taking care of patients' on page 151

<sup>39</sup> Mzuzu is a city in the Northern region of Malawi while KCN has its main campus in Lilongwe in the Central region and a satellite campus in Blantyre which is in the Southern region (See figure 1.1 on page 11). Sometimes students are allocated at Mzuzu Central hospital which is far from the main campus and lecturers can only visit students maybe once in two weeks and therefore supervision is very minimal causing some of the students to relax

<sup>40</sup> Getting out of the mood reflects the demotivation that follows when students are not being guided and this is consistent with what Brown et al (2005) calls falling into a non-learning role.

experiences.’ However, the issue of students relaxing when not supervised should be examined in light of the student nurse as an adult learner who is expected to be self-directed. Arguably, the student nurses at KCN are adult learners and therefore the tendency to relax and abscond when not supervised is similar to what Lofmark and Wikblad (2001) identified as a shortcoming for the students and it hinders clinical learning.

#### 4.4. Biased clinical assessments

Each clinical placement concludes with assessment of student performance and this is done by ward in-charges<sup>41</sup> or other senior nurses in the ward in collaboration with the nurse lecturer who is responsible for clinical supervision in that particular ward. The study indicates that the assessments are conducted in an unfair manner and there is no objectivity. There is bias because most of the times the assessors are not aware of how the students perform because they do not work closely with them and this makes the students to question how their clinical grades are arrived at. Sometimes students are awarded grades which they do not merit and this demotivates those who perceive themselves to be hard-working. Some of the students expressed the following sentiments:

The evaluations that I have been having in relation to clinical learning, I would say they are not fair enough, because I've never had a supervisor come to me (.) they've never seen the way I work at the ward but at the end of the day you get a grade. And you say where is this grade coming from? You look at the nurse; she is not there to work with you but will give you a grade. (.) At the end of the day and you tend to wonder where is this grade coming from? (St-2-F-4)

It's just the nurses who evaluate us. So it happens that somebody who wasn't hard-working is given higher marks than somebody who is hard-working and that person gets demotivated. And most of the students (.) will say I stopped being hard-working because I saw somebody being given a lot of marks (.). I was hard-working and she was lazy (St-13-F-4)<sup>42</sup>

The common concern expressed by the students is that they are given grades and yet both the lecturers and the ward sisters who assess them are not aware of how they perform because they do not work closely with them. While (1991) points out that this is one of the problems in clinical evaluation because ideally the evaluation should be based on a constant 1:1 observation period with a student but the assessments are based on a sample of the student's total clinical experience. This explains why some of the students felt that mistakes performed during the placement become the main highlight during evaluation. In such cases the mistakes became

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<sup>41</sup> The ward in-charge refers to a senior nurse in the ward who has an overall administrative role and this is used interchangeably with the word ward-sister.

<sup>42</sup> The words hard-working and lazy portray strong value judgments which students make of each other and these issues are discussed in chapter 6 under the theme 'Student attributes.' on pages 144-145.

samples of the student's experience upon which the decision for a grade is based. Debatably, it is easier to remember a mistake which a student committed than the many good things which the student may have done. One of the students expressed the following sentiments:

In most of the cases as a student you may have strengths and weaknesses. (.). And unfortunately (.) once you make a mistake that mistake will be the highlight of the whole of your clinical allocation because if you make a mistake to someone who is to grade you, that one can be bad (St-5-M-4)

This present study identifies bias as one of the problems in the assessment of nursing students and this is also revealed in other studies in literature (Hughes 1992; Davies et al 1996; Napthine 1996; Calman et al 2002). Napthine recommends that if clinical competence is the outcome standard for the student, it is essential that the evaluation must be rigorous and consistent and that there is need to gather sufficient evidence to infer competence. This may be what is required to overcome the problem of bias at KCN.

Clinical assessments are significantly influenced by interpersonal relationships such that ward sisters tend to be partial and award good grades to students who have good relationships with them regardless of how they perform. This makes students to avoid anything that will cause conflicts between them and ward sisters, knowing that this might have a negative impact on the clinical grade. For example, sometimes students are left to manage the ward unsupervised and they will not mention it for fear of the impact on the grade. Students strive to be good hence they suffer silently for the sake of getting good grades at the end of the placement. To this end, one of the students expressed the following sentiments:

The senior nurse leaves you on duty alone. As a student, (.) I have never had conflicts to say I can't do this (.). Now what I do is like more of appeasement policy (laughter). (.). So you see, you are in that situation but you are unable to point it out because you know this has an impact, she is going to be the same person who is going to sit down with my lecturer to give me a final mark (St-5-M-4)

Smith (1992) also reflects similar findings in that the participants in her study would not report problems which arose in the ward because they were frightened of

negatively affecting their ward reports. The excerpt above reflects feelings consistent to what students who participated in Smith's study felt in relation to tutors assessing them and this was eloquently captured by one of the participating tutors who indicated that students perceived them as their 'judge' and 'jury.'

These findings also have resonance with what Melia (1987) described in her study as 'fitting in' where students changed their behaviour to conform to the ward sisters. Levette-Jones and Lathlean (2009) reveal that nursing students conform and comply in order to gain acceptance by clinical nursing staff. In common with previous research (Hart and Rotem 1994; Nolan 1998; Cope et al 2000), this present study demonstrates that acceptance of students by clinical nurses is crucial in the promotion of clinical learning and some of the students had this to say:

If you are in an environment where people are not receptive, they don't accept you, (.). They don't want to work with you, you cannot definitely learn from those people. (St-2-F-4)

A nurse who facilitates my learning is the one who in the first place is able to accept me to say though she is doing bachelors but she is a learner. (.) Because the fact that I am doing BSc doesn't mean that I know everything, I need to learn. (St-27-F-3)<sup>43</sup>

Students need to be accepted by qualified nurses as undergraduate students and be given due support despite the differences in the level of preparation. Cope et al (2000) categorise acceptance into social and professional acceptance and indicate that social acceptance is quite significant and may be attained before the student can demonstrate any competence. The study reveals that KCN students utilise different strategies to develop good relationships with ward sisters and other clinical nurses so that they can gain social acceptance. Befriending is one of the strategies and some students even bring food for clinical nurses. The main goal in all this is attainment of a good grade and this is illustrated by the following voices:

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<sup>43</sup> The study reveals that one of the reasons why KCN students encounter problems during their clinical placements is because they are pursuing a Bachelor's degree which the most of the practicing nurses do not possess. This has been discussed in chapter five under 'Student support: encounters with clinical staff' and in chapter eight under the theme 'Emotional labour in caring-learning relationships' see pages 124 -126 and 200 -201 respectively.

The nurses start refusing to observe what we are doing now when it comes to (.) evaluating the competencies they say ah I never saw you doing this and yet they refused to observe whatever you were doing so I feel it's really a challenge. And others would give marks according to favouritism, if you were close to them if you were bringing food from the hostel then you would be friends, even if you were not performing well they would give you good marks. So I feel it's not the right method of assessing us. (St-7-F-4)

Well I would say there is a lot of bias because most of the times it's not the lecturers who evaluate, they actually give the nurse in charge of those different allocations. So if you have a good relationship with the nursing in charge at least that means the evaluation will be better off but then if it's a poor relationship, you are sure of poor grades during the evaluation. (St-26-F-3)

It appears students are preoccupied with the idea of getting good clinical grades and this is congruent with Diekelmann (1992) who revealed that students who participated in her study demonstrated anxiety about their grades. Elcigil and Yildirim Sari (2007) also touches on similar themes in a study which investigated problems that student nurses in Turkey experience in their work with clinical educators and one of the problems included anxiety over evaluation by clinical educators which made students to focus on getting good grades than on learning. This corresponds with the findings in this present study and I would contend that in such cases meaningful learning may not take place but a mere preoccupation with building relationships for the sake of obtaining good clinical grades. Toohey et al (1996) claim that the desire for assessment methods which allow comparison and ranking of students is one of the factors which cause complications when assessing the practicum and I believe this is one of the reasons which cause KCN students to be anxious over clinical grades.

Various modalities are used at KCN to assess students' clinical competence and these include checklists of competencies, a tool to assess for professionalism, case studies and objective structured clinical examination (OSCE). Toohey et al (1996) identified five models of assessment<sup>44</sup> of the practicum and one of them is referred to as the specific competencies model. This is similar to what KCN utilises in the assessment of students' clinical competence. The authors indicate that this model of

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<sup>44</sup> The models of assessment by Toohey et al (1996) are discussed in chapter nine under the theme 'Assessing students' clinical competence effectively.' See discussion on pages 240 -242.

assessment involves identifying the key roles and tasks on which the students are expected to develop competence and performance is assessed in the work place. However, the authors further indicate that the difficulty with this assessment model is that the students might have problems to perform the assessment task and this is evident in this study. One of the excerpts above reveals that sometimes students have problems to perform procedures for assessment because some nurses refuse to observe them.

The study reflects emphasis on assessment of competence and literature reflects some persuasive arguments against such a model of education. The competence based approach is associated with an instrumentalist ideology of nursing education which according to Freshwater and Stickley (2004) has a focus on teaching students to ensure safe and competent performance of nursing skills. Freshwater and Stickley argue that there is more to high quality patient care than the safe and adequate completion of tasks. The two authors also contend that the instrumentalist ideology is appropriate for nursing education based on an apprenticeship model. Chapman (1999) also contends that the artistic and humanistic aspects of nursing such as empathy become de-emphasised in competence based education because it is easier to measure technical aspects that can be demonstrated. Milligan (1998) also argues that there is an overemphasis on outcomes at the expense of students' critical thinking. Indisputably, over emphasis on acquisition of clinical competence and the task centred delivery of care which is prevalent in most clinical settings in Malawi hinders the students from knowing the nuances of holistic nursing care and they end up with a narrow perspective of what caring constitutes<sup>45</sup>. This is clearly portrayed in the discussion on conceptualisation of care in chapter eight where students ably articulate physical care but their accounts do not clearly reflect what they do to provide psychosocial care.

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<sup>45</sup> This is clearly portrayed in the discussion on conceptualisation of care in chapter eight where students ably discuss physical care rendered to patients but fail to articulate what constitutes compassionate care from a Malawian perspective see discussion from page 176 -177

The nature of communication between students and clinical nurses seem to be responsible for the anxiety which students develop over evaluations. This also seems to be one of the factors which compel students to develop strategies that will enable them to gain social acceptance by the nurses and the following voices illustrate this:

Some nurses provoke you deliberately knowing that they will find time to revenge when it comes to signing your competence forms. So sometimes we live by trying to befriend them. Because you want that by the end of the allocation you should have at least good marks. It's not our wish to do that (St-18-M-3)

And sometimes we meet setbacks as KCN is concerned; most of the nurses are of diploma or certificate level and this is also a challenge. they say when you pass you want to take the positions here and be our bosses, no we need to deal with you here so that when you come you will know that you don't just get things on a silver platter. (St-11-M-4)

Students are exposed to different conditions during clinical placements but during evaluations the same standards are applied to assess them. Students are allocated to different clinical settings and yet they are evaluated based on the same criteria without considering the circumstances that characterised their experience. The following voices illustrate these concerns:

The second year group will be split into four. (.). You would wonder those four groups will be subjected to different conditions. They are learning the same staff but they will be subjected to different situations in the various clinical settings. So you would wonder that maybe the best clinical student will come maybe from Mzuzu. How was he compared to the one who was in Blantyre? (St-29-M-3)

Some of us we have been towards where the sister in charge was saying keep it up that's nice. And a particular student was also in a different setting where the sister in charge was saying nothing and was giving no motivation. (.) So I believe there must be criteria which are going to standardise all that so that students when you say this is the best student really it has to be based on performance. (St-5-M-4)

Isaacson and Stacy (2009) assert that the inability to control the clinical learning environment is a significant issue with student evaluation and this is a problem these findings are portraying. There is evidence that not all clinical settings provide



positive learning environments<sup>46</sup> and this study lends support to this position. Students reported that in some settings they felt learning was easily facilitated because clinical nurses were willing to teach and they were friendly while in some settings there was no support and learning was not facilitated. Isaacson and Stacy (2009) also indicate that the ease with which the clinical nursing personnel accept students can impact on their experience. The two authors question how much of the student's performance should be compensated for based on whether or not they had a good learning environment?

This present study also reflects that inconsistency among lecturers is also one of the assessment problems. Students reported that lecturers have different preferences and this makes them to begin to learn each individual lecturer. This is consistent with Diekelmann (1992) who reveals that this impedes meaningful learning as students begin to focus on concerns and priorities of instructors. Another problem which the study reveals has to do with assessing for progressive learning. The evaluation tools which are used at KCN do not reflect that there is progression in the students' learning. Students are evaluated on the same skills from year one to year four and one of the students had this to say:

I would also like to say that the evaluation forms that we are using ah, the ones that I used in first year, second year and in third are not very much different. (.) They don't show that I am progressing from a certain level to another. So I would say that ah there is very little progression in the level of the skills that we acquire as we move from a lower class to the next class (St-29-M-3)

A similar concern was raised by one of the students who participated in a study by Forrest et al (1996:1261) and the student expressed the following sentiments:

They are a waste of time when they come, in your third year and do a bed bath with you the teaching seems to be the same no matter what stage of training you are at.

Papp et al (2003) revealed that a precondition for a good learning situation is that the learning situations are varied and appropriately demanding for each student's level.

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<sup>46</sup> See discussion on page 124.

The study also reflects students' perceptions on case studies and the objective structured clinical examination (OSCE), which are some of the assessment strategies which KCN utilises. Students' accounts indicate that case studies are a good evaluation strategy but they observe some process issues which hinder the effectiveness of case studies as an assessment strategy. Case studies are either submitted for the lecturer to mark or the student makes a presentation and the findings reflect preference for the latter. Students revealed that case studies which they submit for the lecturer's marking are not normally authentic and do not promote clinical learning. There is evidence that some of the case studies which students submit do not constitute what the student did in practice. A common practice involves copying and modifying what may have been submitted by a previous student. Some fake up everything about the case study, but the paradox of it is that such students get a very good grade than those who may have earnestly taken care of a patient and wrote exactly what they did. Students indicate that this is one of the demotivating factors and the following voices illustrate these issues:

There is no learning in case studies, (.) if someone who was in first year and has come to second year and will ask for my case that I did in second year, that means he will only edit it (laughter). (.) We only twist here and there the lecturer will not know but it's only a second edition of the case because we write editions. (St-11-M-4)

Most of the case studies (laughter) we don't do them (.) some students just go to the hospital, they don't even have a patient (.) they will get eighty per cent something and someone who has really been caring for a patient (.) is given maybe a low grade (.) so it becomes like a demotivating factor. (St-14-F-4)

Students also expressed dissatisfaction with the marking of case studies by some of the lecturers. It appears some lecturers do not mark the case studies but they only assign a grade. Students were critical of case studies which are returned after marking and yet there is no single comment but only a grade and one of the students had this to say:

Some other lecturers don't read the case studies. (.) You will find your case study hasn't been marked anywhere but you've just been awarded the marks. (.) But some other lecturers indeed do their work, they do look at your case, they would correct you wherever you made mistakes and award you the

mark that you deserve. (St-23-F-3)

OSCE is perceived by KCN students as a good strategy for assessing clinical learning and this is in agreement with Alinier (2003) who reveals that OSCE provides an integrated way of measuring learning outcomes in skill-based learning. OSCE is increasingly being used in nursing education as an assessment strategy and there is evidence that it has a positive impact on the health professional education and that it can enhance its quality (Alinier et al 2006; Rushforth 2007; Mitchell et al 2009). However, KCN students have concerns over the way OSCE is administered. One of the concerns has to do with the fact that some of the examiners are lecturers whom students have not had an encounter with, they may not have taught them in class and students do not know them personally. This is one of the reasons why OSCE is perceived as being stressful<sup>47</sup>. Watson et al (2002) illustrate the advantage OSCE has in that it is possible to introduce objectivity by using examiners or observers who do not know the students. However, as this study reveals, this is what students do not like. The presence of an examiner who is a stranger arouses stress in the students causing them to perform poorly even with procedures they know very well. Watson et al (2002) supports that due to the examination nature of OSCE some students may indeed perform less well than they would in clinical practice and this illustrates that removing anxiety from the examination process is difficult (Nulty et al 2011).

Students expressed that they find OSCE difficult because their learning in the clinical area substantially involves less than the ideal nursing practice<sup>48</sup> whereas during OSCE lecturers expect them to perform procedures in an ideal way. They cited minimal supervision by nurse lecturers and the lack of resources as being the main cause of the perceived skills deficit. The other concern is about having OSCE in the skills laboratory where there are adequate material resources compared to the hospital settings where students practice and also where manikins are used as opposed to real patients. Some students mentioned that they would prefer OSCE to

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<sup>47</sup> The problem of OSCE as one of the stressors is discussed under the theme 'Stressful experiences.' See discussion on page 86 -87

<sup>48</sup> These issues have been discussed under the theme 'Learning in a hard way' under the subject of theory practice gap. See discussion on page 66 – 67.

be conducted in the clinical setting which would allow them to be examined under conditions which are similar to how they learn. Some of the students had this to say:

Supervision is poorly being done in the ward but if it comes to OSCE there are a lot of lecturers and two at one bay. But we tend to wonder, if we go to the ward we don't see them. (.). How can they test us on what we have learnt if they were not there to support us? (.) OSCE is a fearful thing because we know when we are in the ward we are alone. We don't do the correct things we do short cuts (St-21-F-3)

But all in all OSCE should be done on real human beings, on patients especially in the clinical area where the real materials that we use are (St-30-M-3)

The fact that OSCE should be done on real patients and in the clinical area is consistent with McKinley et al (2001) who recommends that assessment of clinical competence should involve direct observation of practice. Some of the concerns expressed by KCN students concur with some of the critics against OSCE which are reflected in literature. There are arguments that OSCE does not offer 'real world' assessment. Wass et al (2001) maintains that the most rigorously controlled OSCE is still removed from the real world of clinical practice. Watson et al (2002) comment on the artificial nature of OSCE. They indicate that during OSCE students demonstrate competence under a variety of simulated conditions which they claim to be artificial.

#### **4.5. Stressful experiences**

The study reflects some stressors and stressful experiences which KCN students encounter during their clinical placements. This study did not explore the levels of stress but reports its occurrence in general and supports the assertion that nursing is inherently stressful (Jones and Johnston 2000; Bennett et al 2001; McVicar 2003). In common with Rhead (1995) the study reveals that stress is evident during pre-registration nursing studies. Lazarus and Folkman (1984:19) defined stress as:

A particular relationship between the person and the environment that is appraised by a person as taxing or exceeding his or her resources and endangering his or her wellbeing.

Although this study did not explore the impact of stress on KCN students, stress is an important psychosocial factor that may affect academic performance and students' wellbeing (Burnard et al 2007; Jimenez et al 2010). As McVicar (2003) indicates, the effectiveness of the interventions to prevent occurrence of stress depends on understanding of the stress phenomenon. These factors therefore confirm the significance of the findings in this present study. Burnard et al (2007) point out that most of the studies on stress among student nurses have been conducted in western countries. There are few studies in literature which have explored stress among African student nurses (Simukonda and Rappsilber 1989; Gwele and Uys 1998) and the findings in this present study also contribute to such literature.

Jimenez et al (2010) identified three major stressors in a cross sectional study which took place at a Spanish nursing College. These include academic, clinical and external stressors and the results of this present study reflect all these sources of stress. Academic stressors include student-lecturer interaction in the clinical setting, clinical evaluations and the objective structured clinical examination (OSCE). Most of the stressors are clinical in nature, which is expected because the study explored the clinical learning experience and these include lack of resources, relationship with clinical nurses, first day of a clinical placement, fear of contracting infections and death of a patient. The external stressors include personal problems which some students encounter.

The presence of a lecturer in the clinical area is perceived as the most stressful encounter and this makes students to begin to avoid any lecturer who makes them feel stressed. Stress commonly occurs following impersonal<sup>49</sup> approaches to clinical supervision which some lecturers employ. These involve what students interpret as 'policing' and tendencies to shout at students or correct them in an embarrassing manner in the presence of patients. The minimal supervision by lecturers is also responsible for the stress encountered when a lecturer shows up at the clinical area. Students do not become acquainted with lecturers because of their infrequent clinical visits. This is a problem because some of the lecturers responsible for clinical supervision in some of the wards may not be the ones who may have taught the students in class. Consequently, the lecturers that students are not familiar with become a threat to them and this makes clinical evaluation by lecturers stressful. Students also reported that some of the lecturers seem to be on the lookout for mistakes. They give no room for commendation, but seem to be there just to point out mistakes as a student is performing a procedure and this makes students to feel stressed. Stress causes students to make mistakes for procedures they already know and they fail to answer questions. Some of the students expressed the following sentiments:

I can say the most stressful thing are the supervisors<sup>50</sup> from KCN because whenever they come (.) they don't look at positives you are doing, they only look at the bad things. (.) They just come like a cat which catches a rat (laughter) to find you doing something bad. So when you realise that our lecturer is here you are like tensed up and stressed (.) and that's maybe the reason when the students see the supervisor coming most of them run away because they don't want to be humiliated<sup>51</sup>, they don't want to be embarrassed in the ward(St-14-F-4)

Sometimes when lecturers come to the ward you become nervous (.) And then maybe you were doing something right but just because you have seen that person you become like nervous you don't even know what to do when

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<sup>49</sup> The impersonal approaches of clinical supervision which some lecturers employ have been discussed in chapter five under 'Student support: encounters with lecturers' and in chapter eight under 'Emotional labour in caring-learning relationships.' See discussion on pages 120 -122 and 206 – 208 respectively.

<sup>50</sup> The word supervisor refers to a lecturer from KCN who is responsible for clinical supervision in a particular ward.

<sup>51</sup> Shame or humiliation and its impact on clinical learning is discussed in chapter eight under 'Emotional labour in caring-learning relationships' on page 208 - 209.

he asks you what are you doing you even fail<sup>52</sup> to explain to that person what you are doing. (.). The approach is different some use approaches like they are policing you. (St-24-F-3)

It becomes stressful when I am working under supervision when the supervisor has decided to observe you and not to teach you. Even if you are doing something in the right manner but because somebody is observing you or evaluating you, you tend to make mistakes (St-25-M-3)

Simukonda and Rappsilber (1989) conducted a study which explored anxiety among male nursing students at Kamuzu College of nursing and the study revealed high levels of anxiety among male student nurses and this was associated among other factors with the student-lecturer relationship. The findings in this present study have resonance with Oermann (1998) who also reveals that nursing students perceive clinical educators to be their biggest stress inducers. Sharif and Masoumi (2005) also report that Iranian students perceive evaluation by a faculty member as anxiety provoking. Evans and Kelly (2004) also reveals stress among nursing students after being reprimanded in front of staff and patients in a survey which was conducted at an Irish teaching hospital. Thyer and Bazeley (1993) also identified interaction with some lecturers as one of the stressors and Isaacson and Stacy (2009) confirm that students are often nervous when interacting with faculty in the clinical area and profess that that they perform better in the absence of faculty. However, this present study reveals that a faculty member becomes a threat to students when the students do not know the faculty member personally or if the faculty member tends to shout at students or employs a 'policing' approach to clinical supervision. The study suggests that students encounter stress when interacting with faculty members when there is lack of student-lecturer relationship.

KCN students perceive OSCE as being quite stressful. This is an assessment strategy which requires each student to demonstrate specific skills and behaviours in a simulated work environment (Mitchell et al (2009)). It consists of a series of short assessment tasks designed as OSCE stations, each of which is assessed by an examiner using a predetermined, objective marking scheme (Bartfay et al 2004; Major 2005). One of the KCN students expressed the following sentiments:

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<sup>52</sup> The impact of a threatening environment on students' rational thinking is discussed in chapter eight under the theme 'Emotional labour in caring-learning relationships' on page 207 - 208.

OSCE is very stressful (.) when you see the lecturers (.) some lecturers just reading by their faces you tend to develop fear to say will things go well with me? So in OSCE you have different faces of lecturers, others you've never been with them in class but you just find them there so it is so stressful. (.) they give us ten minutes to conduct the procedure and prepare equipment, it is too small for us so you become stressed and you tend maybe to miss out whatever you are doing (laughter). (St-23-F-3)

These findings are consistent with existing literature which supports that nursing students perceive OSCE as being stressful (Bujack et al 1991; Rushforth 2007; Nulty et al 2011). For the KCN students, Stress during OSCE is associated with involvement of lecturers whom students are not familiar with. This is consistent with Gillespie (2002) who reveals that knowing the teacher has a positive influence on student's trust and ease with the teacher. Rushforth (2007) also confirms that students find OSCE enormously stressful to an extent that the stress could adversely affect performance. Stress during OSCE is also related to time allotted per station which KCN students perceive as being inadequate.

KCN students gain their clinical practice experience in resource poor settings and the lack of resources is regarded as a major clinical stressor, more especially when it leads to death of a patient. Such stressful encounters occur in cases where a health facility lacks some lifesaving drugs and some of the students gave the following accounts:<sup>53</sup>

The patient with COPD who is of course sick but you know that if he had this drug or this care, he wouldn't be dying, but because of the inadequate amount of drugs the patient is dying. So it would be stressful. You've done all for the patient, but at the end of the day the patient dies just because there is no just a single medication for the patient to survive. So it was really bad. (St-2-F-4)

The issue of resources it's not an issue that you can just talk about, it's an issue that you can even feel; and I have ever seen several situations in a hospital where even lives are lost because you don't even have resources (.) So if you don't have the resources it's so stressful and when you stand there with your knowledge, your skills, everything but you can't do anything and it's so stressful. (St-5-M-4)

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<sup>53</sup> These accounts portray the emotive aspect of nursing in Malawi and this is discussed in chapter eight under 'Nursing in Malawi: an emotive subject' from page 213 -214.



In common with these study findings, the Malawi project (2010) also confirms that in Malawi's referral hospitals supplies and medicines that are required to save lives are often not available.

Some of the stressful clinical experiences which KCN students encounter have to do with their relationships with clinical nurses. When students are in the clinical setting they expect that clinical nurses will be readily available to support them with their clinical learning but this is not always the case. Some of the clinical nurses decline to teach KCN students because they are busy and others openly tell the students that they cannot teach them because they are pursuing a bachelor's degree and they will be their bosses when they graduate. Some of the clinical nursing staff display negative attitudes towards KCN students and some even shout at them which students also perceive to be considerably stressful. Some of the students gave the following accounts:

Sometimes you could have that interest to learn something but not having support for you to learn that thing. You ask the nurse to supervise you they will tell you no, I'm busy. Even sometimes other nurses will say how can I teach you when you are the one who is pursuing a degree. (.) So it was stressful because you want to learn but the people are not supportive (.)and the supervisor<sup>54</sup> does not come regularly. So it was stressful that sometimes you say should I go to the wards? Just having the demotivation. (St-10-F-4)

When I was in first year, we were allocated to (name of hospital & ward) and we found that there was a poor relationship between the sister in charge and third year students. So this nurse was projecting her anger on every student that was at that ward so actually we didn't learn much (.) this was a very stressful moment for us because whenever we were in the ward this nurse was saying abusive words to us, shouting at us, saying a lot of things so I can say that was the most stressful experience that I had. (Ma-14-F-4)

Burnard et al (2007) reflects similar findings in a study which explored stress among Bruneian nursing students and the results indicate that where qualified nurses were willing to teach students, stress seemed less evident but more commonly senior nurses did not adopt supportive roles. Literature also reflects other relational factors

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<sup>54</sup> The word supervisor refers to lecturer from the KCN who is responsible for clinical supervision in a particular ward

associated with stress among nursing students for example, Evans and Kelly (2004) identified that the unfriendly atmosphere on the ward or the aloof attitude of more senior nurses induces stress in students. The fact that KCN students are pursuing a bachelor's degree whereas most clinical nurses have lower qualifications seems to be a main cause of some of the relational problems which students encounter in the clinical settings. This is consistent with the assertion by Andrews et al (2006) that the transfer of nursing into institutions of higher education has led to tensions among graduate and non-university trained nurses.

The study reflects some unique challenges which KCN students encounter during their clinical placements. I interpret these as unique challenges because I believe they are exclusive for the CLE<sup>55</sup> in Malawi. KCN students reported that sometimes they are left unsupervised and they have to take care of critically ill patients independently. This happens regardless of the level at which the students are. Consequently, critically ill patients are entrusted into the hands of less experienced students who may not be competent to take care of such patients. To this end, students reported of not knowing what to do or being 'stuck.' This causes students to work in fear dreading the outcome to the patient as well as to themselves should a mistake happen. This causes considerable stress among students and it's a problem which occurs during both day and night shifts. Some of the students gave the following accounts<sup>56</sup>:

in most of the hospitals what I have seen is that when students go on a clinical allocation, they take that as a replacement for shortage of staff and instead of you working with senior nurses to direct you (.) you would see that they are leaving you alone to do nursing work and there are times you don't know what to do, there is no senior, you are alone as a student and you are stuck (.) you fear what will happen to me. So I also look at that as one of the stressful moments (St-5M-4)

Some nurses think that our presence in the ward it's a relief. (.) They will leave critical conditions that they are supposed to take care of (.) and they will put so much pressure on the students which becomes stressful at times. For example during night duties, when students are there they will just give

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<sup>55</sup> CLE stands for clinical learning environment

<sup>56</sup> These excerpts reflect the emotionally charged situations which confront students during clinical placements and these issues have been discussed in chapter eight under 'Emotional labour during caring encounters' on pages 187 – 188.

drugs at 9:00pm and go to sleep (.) you tell them there is this patient, and they will just say ah do ABC the patient will be ok not knowing that there is a great complication and when something goes wrong they will always push it on you though they are the ones to blame, so that too is a challenge. (St-7-F-4)

we were on night duty, it should be year two (.) the Sisters would go to sleep and they would say when you have problems just deal with those problems we are sleeping don't disturb us. So you would find that you don't know how to handle the problem. (.) That was so stressful to us (.) So you would weigh and say its better somebody shouts at me than to lose the patient's life. So that was one of the stressful moments. (St-8-F-4)

In common with previous research (Hamill 1995; Neary 1997; Sharif and Masoumi 2005; Burnard et al 2008), these findings reveal that lack of clinical competence and the resultant fear of making a mistake when caring for patients can lead to stress. The results also indicate that trying to solicit assistance from clinical nurses can be stress provoking sometimes, more especially during a night shift. As one of the excerpts above reflects, what causes stress is the fact that nurses tell the students not to disturb them because they are sleeping and the students know pretty well that if they should try to disturb the nurses, before they offer any help they will shout at them first. Being shouted at is one of the major concerns which KCN students expressed and it arouses stress. Students are shouted at by either clinical nurses or lecturers and sometimes even by doctors and one of the students described it this way:

When you are being shouted, you are being scorned by maybe a nurse or a lecture yah during a procedure I feel it's stressful (.) and when somebody has shouted at you in the first place and is coming again to you, you will always be stressed (.) So I feel being shouted by a lecturer, or maybe nurses or doctors I think it's not good, it's stressful (.) and you are not free to ask questions (St-13-F-4)

This in a sense reflects bullying<sup>57</sup> and shows that in some settings the CLE is quite hostile and oppressive. Such interactions hinder students from asking questions and obviously impede their learning.

First day in a new clinical placement is stressful to some students and the stressors mostly include new staff members and new clients. Ward orientation which normally

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<sup>57</sup> Shouting at students has been discussed further in chapter eight under 'Emotional labour in caring-learning relationships' on pages 201 -202 and 208 – 209.

takes place at the commencement of the placement helps to resolve such type of stress. Knowing the staff and the patients and developing good relationships with them helps the students to settle and to work in the ward without stress. This explains why in some clinical settings students continue to work under stress because of the prevailing poor relationships. Sometimes students are also stressed when they just commence a placement because of what they may have heard in the grapevine. Students normally inform each other about ward sisters and even lecturers whom they perceive to be difficult and these constitute major stressors to students. One of the students had this to say:

I was allocated to (name of ward). Now the stressor was the ward in charge because I heard rumours from my friends the in charge is very difficult, she wouldn't allow you to seat down and all sorts of things that people would say about her. So by just looking at her it was a stressor to me. (St-8-F-4)

Smith (1992) also reflects similar findings in a sense that one of the factors which influenced students' ward experience was what they heard on the grapevine from fellow students.

Some stressful encounters occur following death of patients and there are several factors that lead to stress in such cases. Sometimes when a patient has died the student begins to analyse what she did and begins to think of the alternative actions she should have done for the patient not to die. One of the students revealed that she had such an experience in year one and this made her to avoid taking care of chronically ill patients fearing that they might die and dreading the stress that would follow. Stress also follows when a patient who has a good relationship with the student dies. In such cases most of the times death of the patient is not expected. Sometimes students are blamed for mistakes which they are not directly responsible for. It appears sometimes nurses cover themselves up by putting the blame on students which also causes stress. To this end, one of the students gave an account where she was blamed for 'killing a patient' because she had inserted a nasogastric tube and the patient died several hours later<sup>58</sup>. Sometimes a patient dies immediately after a student has administered a prescribed drug or sometimes after the student was

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<sup>58</sup> It would have been good to include the excerpt but it's quite lengthy

carrying out some interventions on the patient and this makes the student to feel guilty. These issues are illustrated in the following voices:<sup>59</sup>

The most stressful thing that I can say was something about death. Because I can say when somebody dies it's something that is demotivating to the student because when you are in year one what it feels like is when you give nursing care that person at least has to improve and when that person has died, you feel stressed you start analysing all those things that you did for the patient (.)and for you to look after someone who is chronically ill it's like you don't have that courage.<sup>60</sup> (St-10-F-4)

I had a shock when a client died again, that was now in second year (.) until my father explained to me to say alright it happens when you are so much attached to someone that it becomes difficult for you to accept it (.) and even that counselling<sup>61</sup> it's what has helped me to cope with any scenario when I met a client who has died (St-27-F-3)

Um sometimes a client would die soon after you have done something to the client so eventually it was difficult for yourself to accept that the client has died due to something like a natural death that may have contributed to that. (.) We used to give drugs based on the way they have been prescribed and sometimes clients could die so it was difficult to continue working you just feel guilty that I have killed a patient (St-6-M-4)

In common with previous research (Rhead 1995; Timmins and Kaliszer 2002; Burnard et al 2008), this present study reveals that death of a patient can be stressful to students and there are several factors that lead to such stressful experiences. The study also reveals some coping strategies which helped some of the students to cope with stress associated with death of a patient. These were not explored in this study but some of the students' accounts reflect this. For example, one of the excerpts reflects how a student learnt to cope with death of a patient after her father counselled her. These findings are consistent with existing literature which also portrays support from family and friends as a coping strategy (Lo 2002; Brown and Edelmann 2000; Sawatzky 1998). The student who was blamed for 'having killed the patient' obtained emotional support from her lecturer and she had this to say:

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<sup>59</sup> These excerpts portray the emotionally charged situations which KCN students encounter due to death of patients and these issues are discussed in chapter eight under the theme 'Emotional labour and death and dying' on pages 210 -212.

<sup>60</sup> The excerpt reflects a situation where the student holds herself accountable for the patient's outcome hence the ensuing stress. These issues are discussed in chapter eight on page 211

<sup>61</sup> Counselling from the father is discussed further in chapter five as a form of lay support which enabled the student to cope with death of a patient on page 103

During the stress<sup>62</sup> that I had, she (*lecturer*)<sup>63</sup> was there, she helped and I changed my mind that ok I can also start doing the procedures because she helped a lot. Otherwise if it couldn't have been that I could have even voluntarily come to say oh I don't want to kill more patients I just want to go home because it was really bad (laughter) yah. So emotional support was there instead of shouting at me like some supervisors do (St-15-F-4)

This was quite a stressful moment for the student and this is what she said, 'I was confused saying ah how can they say I killed the patient because the patient was ok and I did the NGT itself was fine.' She even had to go to the mortuary to call the relative of the deceased patient to give witness of what happened from the time she performed the procedure and what happened at night with the night nurse. It appears students are sometimes blamed when in the real sense it is the fault of a qualified nurse and this is what the student further stated, 'so it's like instead of the nurses accepting their own mistakes when there are students and something happens, they always put it on to the student.' The words emotional care mentioned in the excerpt refers to the support that the lecturer gave the student while the issue was being handled. The lecturer resolved the issue amicably and averted a possible case of attrition. These findings are congruent with Brown and Edelman (2000) who identified academic staff and personal tutors as potential sources of support to students.

Fear of contracting infections is one of the clinical stressors for some of the students. Malawi is one of the countries in the Sub-Saharan region which has been severely affected by the HIV pandemic and needle prick injuries appear to be one of the causes of stress among students. Besides HIV, other infections such as tuberculosis are also common and the study reveals that fear of contracting such infections can also be a source of stress and the excerpts below attest to this:

When we were in paediatrics I was putting up blood transfusing but that kid was HIV positive and as I inserted a cannula then that kid pushed me and blood splashed into my eyes. And by then I had sores in my eyes but then I felt to

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<sup>62</sup> The student was blamed by one of the clinical nurses for a 'killing a patient' on whom she had inserted a nasogastric tube and fed the patient and the patient died almost eight hours later. The nurse was trying to cover up her own negligence because she did not attend to the patient when the relative reported that the condition had changed

<sup>63</sup> The word lecturer in italics has been inserted to promote clarity of the sentence

say what then? But I didn't go for testing (.) but I went after a week and the results were negative. But just three days ago I went again, I had stress to say eh what if I have it, what then, will I continue with my education or not?. (St-23-F-3)

When I was allocated to go to TB ward, the feeling I had was that by the moment I will be leaving the ward I will be infected as well. (.) So that alone stressed me, it was so stressful to me working in TB ward, I would put on mask every time. Where I don't have any mask I would hold my breath. (St-8-F-4)

When I was in TB Ward for the first time it was stressful for me because (.) I learnt that it is an airborne disease so when I went there, I failed<sup>64</sup> even to care for the patient because what I was thinking is my safety. Am I going to come out safe without having this disease? So it was also a stressful allocation for me in TB Ward, yah. (St-1-F-4)

The external sources of stress mainly relate to personal problems which some of the students encounter. The study reveals that having personal problems can be stressful and can cause poor academic performance because students become engrossed with the problems and do not concentrate on their studies. The possible causes of these personal problems include problems at home, financial problems, being an orphan and relationships with other students and some of the students had this to say:

Sometimes (.) you may have some problems maybe at home, some other issues (.) you may become disturbed, you may not concentrate, you may not work hard. And you become confused and you don't know what to do and who to talk to and in most cases such issues it's difficult to just stand up and start talking about them because some of them sometimes are sensitive issues. (.) Sometimes you are so absorbed with your personal problems (.) you also silent yourself, you are depressed (.) the only thing that can happen is failing exams. (St-5-M-4)

Maybe you lost both of your parents and you are staying with relatives. Those relatives sometimes they have their own priorities you may not be the priority. So probably you have run out of pocket money or maybe you have some other issues at home (.) ok even in school you need support (.) But you don't get such type of things. Sometimes you feel like (.) am I really belonging to somewhere or I am just here alone. (.) Sometimes it's not necessarily financial support (.) but then moral support is very important. You need to feel a sense of belonging it keeps you going because you feel

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<sup>64</sup> Failing to care for the patient reflects the detached stance which students sometimes employ to protect themselves. This is commonly portrayed when students care for patients who are HIV positive and these issues are discussed in chapter eight under the theme 'Emotional labour during encounters with HIV/AIDS patients on page on pages 192 - 193.

you are loved. (.). In the end you are psychologically affected you cannot concentrate to work or study in class. (St-20-F-3)

I have seen a number of students having problems when they are going to the clinical area. For example, a student is given soap for washing clothes but some do not have enough school uniforms. You find that the same uniform that he is using in the ward is supposed to be used also tomorrow. As a result they are forced to be washing it each and every day (.) Sometimes they even say I am unable to go to the ward on time because I was busy ironing it because it wasn't dry over the night. (St-30-M-3)

In common with previous research (Thyer and Bazeley 1993; Brown and Edelmann 2000), this present study confirms that financial concerns can lead to stress among pre-registration nursing students. The financial pressures and other problems which students mentioned relate to the fact that some of the students are orphans. Arguably, it is also possible for students who have parents to experience financial problems as well because 52% of Malawi's population are relatively poor (National Statistical Office 2005). Consequently, some students only have one pair of uniform and the problems associated with this are evident. Financial problems also hinder students from having basic equipment such as sphygmomanometer, stethoscopes and thermometers which students need for their clinical experience. This present study reveals an important factor which can negatively impact students' learning in general. It reveals that personal problems produce considerable levels of stress among students and can lead to student failure. This is an area which requires further research to inform policy on student bursary and loans and student counselling.



#### **4.6. Conclusion**

The study findings in this chapter reflect the problems and challenges which KCN students encounter during their clinical learning experience and it is evident that problems within the CLE are responsible for such challenges. KCN students gain their clinical practice experience in clinical settings characterised by severe nursing shortage and gross lack of material resources. Students therefore significantly contribute to patient care and other ward routines leading to high workload. This in turn causes the students to feel physically fatigued and also hinders clinical learning. Students learn most of the nursing skills by improvising because of lack of supplies. Consequently, they perceive that they 'learn in a hard way.' The lack of material resources also demotivates and frustrates them and hinders them from learning ideal nursing practice. Students observe that in class they learn ideal nursing but the practice in the clinical settings is different and this illustrates the theory practice gap. The study also reveals that KCN students are not adequately supervised by lecturers during clinical placements but they are left 'on their own' and they learn 'on their own' through trial and error. Assessment of clinical competence also poses significant challenges to KCN students. There is evidence of unfairness and subjectivity which demotivates students. At the same time, assessments are significantly influenced by interpersonal relationships and students become so much preoccupied with building good relationships with clinical nurses knowing the impact of such relationships on the clinical grade. Finally, the study reflects some stressful experiences which KCN students encounter and the sources of stress are academic, clinical and some external stressors such as financial problems. While in this chapter the findings portray the problems and challenges which students encounter during clinical placements, in the chapter that follows, I present findings that touch on how students experience clinical learning, the emphasis being what they learn, how they learn and the available support.

## CHAPTER 5: EXPERIENCING CLINICAL LEARNING

*Facilitation is an essential component of learning through practice. Without it, students become aimless in their endeavours to glean anything worthwhile from their experiences (Birchenall 2001:249)*

This chapter presents findings which reflect students' encounters or experiences of learning in the clinical setting. The study reveals the significance of the clinical experience in students' professional socialisation and the factors that positively or negatively impact on this socialisation process. Students' accounts also reveal some of the learning outcomes attainable during their educational programme. The study reveals that nurse lecturers have a potential to facilitate clinical learning but there is role failure because of their infrequent and brief visits to the clinical area. Students are encouraged and motivated by the presence of lecturers who utilise humanistic approaches in the facilitation of clinical learning. Conversely, students avoid lecturers who utilise approaches that demean their self-worth. The study reflects students' perceptions of attributes that characterise good or bad nurse educators.

Encounters with nurses and doctors are quite significant in the promotion of clinical learning. However, there is evidence of variable commitment to the teaching role by clinical nurses. Some are willing to support students' clinical learning whereas others are not. Some nurses display negative attitudes towards KCN students and this seems to be associated with the fact that they are pursuing a Bachelor's degree, a qualification which most of the practising nurses do not possess. The study reveals that availability of support, interpersonal relationships and approaches of clinical supervision are some of the factors which facilitate or hinder clinical learning. The results in this chapter are discussed under the following themes; learning to be a nurse,<sup>65</sup> student support: encounters with nurse lecturers,<sup>66</sup> and student support: encounters with clinical staff.<sup>67</sup>

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<sup>65</sup> Identified as a category because the findings presented reflect what students encounter during their professional socialisation, how they learn the art of nursing and some of the clinical learning outcomes.

<sup>66</sup> Identified as a category because the findings presented centres around student support by nurse lecturers and factors that enhance clinical learning through the nurse lecturer-student encounters are also presented.

<sup>67</sup> Identified as a category because the findings touch on issues of student support by clinical staff

### **5.1. Learning to become a nurse**

Despite the problems and challenges associated with clinical learning, the study findings indicate that the experience is beneficial. The clinical experience promotes integration of theory with practice and supplements what is learnt in class. It enables the students to get a real picture of the various clinical conditions they learn in class hence consolidating the learning. It allows learning from real life situations and gives a broader picture of patients' illness experiences. Generally the learning that takes place during the clinical placements is quite substantial and the following voices illustrate this:

In class we have learnt about most of the conditions (.) but maybe you don't have that picture how these things look like (.) So in the clinical setting you really have a picture and you try to remember what you learnt in class. (.) So in the clinical setting indeed we learn more (St-1-F-4)

I would say when we are in classroom there are things which are hard to understand when the lecturer is teaching (.) but when we have a patient in a hospital setting it's easier to care for the patient (.) So I would say it's easier to learn in the ward. (St-26-F-3)

Students reported that substantial learning takes place during the clinical experience compared to the learning that takes place during theory sessions in class. Clinical learning helps to put what students learn in class in a proper perspective hence promoting their understanding. Cope et al (2000) indicate that the main importance of the placement is to put learning into a meaningful context. This study therefore reveals that students value the clinical practice experience and this is consistent with previous research (Papp et al 2003). Although much learning takes place during clinical placements, the quality of the learning experience is compromised because of existing problems within the CLE. The study reveals that how much and how well students learn depends on the environment and one of the students had this to say:

I have been to various clinical placements ah some of which I learnt a lot and others I hardly learnt. Ah it depended on the environment itself; others the policies and procedures were very straightforward they were systematic it was easy; others there was no order at all so it was hard for me to place myself as in what are my expectations. (.) How much you learn and how well you learn depends on the environment. (St-22-F-3)

Students' learning mainly constitutes learning how to take care of patients with various medical or surgical conditions and the performance of various nursing skills. Mastery of nursing skills is the main concern for the students as they take care of patients. This reflects the technical preoccupation that characterises student nurses in the early years of their educational programme. Students value greatly the acquisition of nursing skills such as insertion of a cannula and one of the excerpts below bears witness to this:

When all of the enrolled nurses have failed to do a certain procedure they have high expectation that a nurse from KCN does this and saying eh we have failed to put up a cannula it's really shameful yah. But when they know that ah if we call the nurse in-charge she will put it, then it will be better yah. (St-21-F-3)

These findings are consistent with previous research (Lee and French (1997; Crawford and Kiger 1998; Gray and Smith 1999; Corlett 2000). Lee and French (1997) reveal that the students who participated in their study were primarily concerned about learning technical and medical knowledge and this was considered as a 'real learning experience' and personalised nursing care was considered as menial task and did not constitute real knowledge.

Clinical learning outcomes for KCN students also include autonomy and ability to function independently. As already discussed, students are left unsupervised most of the times and although this negatively impacts on their clinical learning, some of the students indicate that it helps them to learn to work independently and this is illustrated in the following voices:

When we were like in (name of hospital) the level of supervision was very minimal because we were most of the times alone so I think it wasn't that good. (.). We were learning to be independent (St-23-F-3)

I have also learnt that we have to be independent because there are certain times whereby we are faced with patients and let's say there is no supervisor, I mean not even a lecturer and not even a staff member from the hospital setting.(.) I have learnt to intervene independently. (St-26-F-3)

As students' progress with their studies they also learn the professional aspects of

nursing and this is mostly through some nurses whom students view as role models. Students admire the way these role models conduct themselves and emulate their behaviour. This has helps some of the students to develop a compassionate and understanding heart, a listening ear, sympathy, empathy and passion for patients. Some of the students gave the following accounts of some of the professional values they have attained:

From some of the nurses I can say I have learnt the professional behaviour (.) like the character of compassion, understanding, (.) sometimes a guardian<sup>68</sup> may call you while something is not wrong, (.) but for you just to go to that patient, that guardian will remember you. But look at what you did, (.) you can't find a rationale how it helped the patient. (.) But I have learnt that it has such meaning, a lot of meaning to the people than we expect.... (St-10-F-4)

I can say I have learnt that the attitudes that we have for the patients they really help by themselves, they really matter in the patient care because the patient may be critically sick and we may be giving her medications but if we don't have that passion inside us and to be there to help the patient I think recovery takes a long time. (St-14-F-4)

Different people come into the ward some of them very poor some of them very rich and from different cultures. I mean being a person not doing nursing there are some other things that a person would choose (*not to do*).<sup>69</sup> Let's say ah this person is looking very shabby I wouldn't associate with such a person. But then I have learnt how to have sympathy, not only sympathy and even empathy. Because when we have a patient right in the ward there is a certain connection between me as a nurse and the patient regardless of their status. (St-26-F-3)

Lemonidou et al (2004) also reflect in a study how student nurses develop an awareness of personal values through empathizing with patients. These findings portray some professional values which students develop and these are essential in the provision of compassionate care. These convey a departure from a preoccupation with mastery of nursing skills which characterises novice students. I particularly find the following statement quite emotive, 'there is a connection between me as a nurse and the patient regardless of their status' and I would argue that such a value forms the foundation for providing emotional care. The study also reveals that there are

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<sup>68</sup> A guardian is a relative or other significant person who stays with the patient in the ward during the period of hospitalisation. Due to the severe nursing shortage most of the patients will normally have a guardian.

<sup>69</sup> The words not to do in italics have been inserted to promote clarity of the sentence

some nurses within the clinical settings in Malawi whose conduct and performance encourage and motivate students to work hard. Students identify such nurses to be the type of a nurse they want to be and one of the students had this to say:

But when you go there (*clinical area*)<sup>70</sup> and find a nurse who is polite (.) who has love for patients. When she talks to a patient you could actually see that this person actually has love for the patient. When you see those nurses you are motivated, you say ah I would like to be a nurse like this one. (.) If I work like this maybe I will also change the image of nursing. (.) You find there are nurses who are very caring; they are much concerned about patients. There are nurses who even when they go home they would call to ask how is that patient that I left in this condition; so you could actually see that this person has got that connection with a patient (St-10-F-4)

There are some people (*nurses*)<sup>71</sup> who've got caring at their heart they can have problems at home but when they are coming from home, coming now into the ward, they will leave the problems at the door of their homes and then they will meet the clients in the ward and they will not carry their problems. Now when you meet such kind of a nurse, you learn a lot; but when you meet a nurse who is looking at the monies, I should say they have a bigger eye on the money not on the client usually it becomes a problem because, you will not usually find them in the wards you have to start searching for them. So when you meet such kind of nurses then also learning becomes difficult (St-27-F-3)

The study findings reveal some experiences in the professional socialisation of KCN students which are specific for year one and such experiences portray their learning trajectories. There is evidence that some students commence their nursing studies with enthusiasm and excitement and there are some who commence their studies with fear. Debatably, this might be due to whether nursing was a first choice or not. This however was not adequately explored in this study. I will begin by presenting findings on students who were enthusiastic and excited at the commencement of their nursing studies. The study reveals that these students were excited to perform various procedures in order to learn and some of the students made the following comments:

But also what I can say is that when you are in year one you learn much because you are excited. Like the way I remember when I was in year one,

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<sup>70</sup> The words clinical area in italics have been inserted to promote clarity of the sentence

<sup>71</sup> The word nurses in italics has been inserted to promote clarity of the sentence

we were so excited, even to do vital signs you felt as if you have done something that is big and even preparing dead bodies eh. You could actually, maybe you are in another ward and death has happened in another ward, we could actually call each other, a death has happened here so you would go there and you learn (St-10-F-4)

In first year you know you tend to have such interest to say you have to know, yes I think I have to know this. Then when we were there I was showing much of my interest in procedures like catheterisation, removal of sutures. (St-23-F-3)

Jackson and Mannix (2001) also reveal excitement among first year nursing students at the prospect of entering a health facility. However, this present study indicates that the excitement dies away as the programme progresses and for some students it dies away quite early as they begin to experience the realities of nursing practice. Smith (1992) also points out that nursing students who participated in her study demonstrated that they were initially enthusiastic but at the end of three years of their training they became cynical and disillusioned. The extract below reflects an account in which a student from KCN lost the excitement and zeal for nursing and almost felt like quitting. I reflect part of the interaction I had with the student during the interview just to portray how the student changed from being excited to almost reaching a point of wanting to quit and what restored her passion.

**P<sup>72</sup>:** My very first days in the clinical area (.) were so fine in a sense that I was excited (.) putting on a uniform, having to have a stethoscope, a thermometer (.) And then I was looking back at the days when I would see qualified nurses putting on their full uniforms and doing all the procedures in the ward. I imagined, this time around it's me and I want to do it. So I was excited, but unfortunately when I went right there practically doing the work (.) it was very hard and challenging and I thought maybe this is not what I am supposed to do, yes. (St-20-F-3)

**I<sup>73</sup>:** So it looks like when you joined you were full of excitement but when reality dawned on you, you felt um.

**P:** Yes especially looking at for example, in surgical wards when you have these patients coming in some of them coming with very big wounds, septic wounds. (.) Sometimes it was not possible for me to do everything and because I was coming from secondary school whereby I had frequent breaks

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<sup>72</sup> Speaker identifier for participant

<sup>73</sup> Speaker identifier for interviewer

in between and then this time around I was really working in the wards (.). Sometimes guardians or patients would come to me and ask me questions of what I was not familiar with and didn't have the answers. So it was somehow somewhere so frightening and I was thinking I'm I going to do this? (.) So it was challenging despite all the excitement that was there I also had this challenge to say I have to do my best in the clinical area, I have to do my best in class. (.) So it was just too much for me, I couldn't just capture everything. That's why I was let down to say maybe this is not what I am supposed to be doing.

**I:** So how did you cope finally because now you are in year three which means you can go on? How did you cope?

**P:** Ok I would go home during the holidays; my parents would ask me how the whole experience was? I would explain and somehow somewhere because I had this thing to say I want to be an air hostess, I will be putting on this fancy uniform or else I want to be in an office in the bank (.) and now I have to be putting on flat shoes, white uniform every day. (.) and I would say I think this is not it. But by and by my parents would explain to me would actually say you are not doing this for fun but in the end you will find that it's fun because you will get everything you want. This time around it's a profession, if you were in a, whether you were an air hostess, you would also have some limitations of which this time around you think it's ok, it's alright, it was going to be fine but when you go there you will also have to see all these limitations (.). So I coped and then I later on learnt to love my work (St-20-F-3)

The statement, 'I thought maybe this is not what I am supposed to do' signifies doubting choices and Beck (1993) also reflects similar findings in a phenomenological study which explored nursing students' initial clinical experience. As the excerpt above indicates, support from parents restored the student's passion for nursing. In this study parents were quite instrumental in helping some of the students to cope with the stresses of a nursing programme and this is an under reported or under researched area within nursing education. I have already discussed in the previous chapter how another student was able to cope with the stress of death of a patient while in year one when her father counselled<sup>74</sup> her. In common with a study by Price (2004), these findings indicate the importance of lay support to learners. Price explored how post registration and undergraduate nurses completing a Bachelor of Science degree in nursing studies by distance learning utilised lay support to manage competing demands and the study revealed that lay support

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<sup>74</sup> See discussion under the theme Stressful experiences on page 92.



contributes substantially to students' progress.

In the extract below I reflect part of the interaction I had with one of the students who commenced her nursing studies with fear<sup>75</sup> and I also reflect what resolved her fear.

**P:** Alright, considering year one (.) I can't say much because I couldn't tell whether I was learning much sometimes because I was having much of fear to say am I going to make it and all that and having the fear maybe from friends as in, oh this lecturer is difficult he or she will need you to do this ... (St-27-F-3)

**I:** I think these issues remind me of what you mentioned earlier on about year one, you said you had a lot of fear. Can you say something about the fears you had in year one.

**P:** Alright, mostly when I come across someone who is sick what comes to me first is, not the fear as such but then feeling sorry for them. Now in first year I never learnt or I didn't have that knowledge of saying when you are feeling sorry for someone what you need to do is to help them so that they should get better (.). But then after some time that's when I learnt that when you feel sorry for someone make sure you help them to come out of that condition. And people do not believe it today I tell them I like working with patients because what makes me to be so excited is when I see someone coming out of the hospital. They were very sick but then they are able to talk, they are able to walk; they are able to do things which they couldn't do on their own. And not only that because I have also learnt to say when you assist a client it's not only the positive thing that can come out, they can also die and I have learnt to accept it that when I am caring for someone they can die<sup>76</sup>

**I:** So at what point did this excitement start?

**P:** Um second year, I started gaining those encouragements when I was doing surgical nursing because I think in the surgical department the patients

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<sup>75</sup> The fear discussed in this chapter arises from being overwhelmed by patients' suffering and in chapter seven I reflect fear associated with death of a patient. See discussion on pages 153-155

<sup>76</sup> The student indicates that she learnt that when caring for someone they can die because she is one of the students who indicated that she had fear of seeing a dead body, she mentioned that she was shocked when a patient died and screamed in the ward and it was her father's counselling that helped her to cope with death of a patient. See discussion on these issues in chapter four under 'Stressful experiences' on page 92 and in chapter eight under the theme 'Emotional labour and death and dying' on page 210 - 212.

(.) just needs an operation and then they will come back to normal. I will give an example a client with bowel obstruction. (.). After an operation, after a few days then the client was able to eat, was able to talk, was able to walk and do everything. That's when I said ah it's not only negative things that can come out. Now when I had a chat with the nurse in-charge on the client, she told me to say you know what it's not only in the surgical department, it's the same with the medical department. And then she said I am giving you an assignment, do your level best in caring for clients in a medical ward you will see even positive results. When I went there alright it was like an assignment alright I should do my level best to make sure the client gets better and I saw people coming out (*recovering*)<sup>77</sup>.

Smith (1992:118) also reveals similar findings and one of the students in her study said, 'I don't think I learnt much in my first six months as I was frightened..... I don't remember a great deal about it..... I think it is because I was all tensed up, really.' Some of the nursing students in Malawi develop fear from doubting whether they would be able to make it and it is the situation in the wards which makes them to have such feelings. Fear might also be attributed to being overwhelmed by the patient's grief and suffering (Christiansen and Jensen 2008) and the excerpt above confirms this. What students hear in the grapevine about lecturers and ward sisters also instils fear in them. This makes them to develop fear and anxiety to a point of avoiding lecturers when they come for clinical supervision. Fear and anxiety affects students' interaction with both clinical supervisors and clinical nurses and it generally makes the clinical experience difficult. One of the students had this to say:

But when you are in year one most of the times you are afraid of the nurses and you don't know what they are expecting of you so it becomes difficult for you to ask questions (.).Ah on the part of supervisors like lecturers, in year one it was difficult to work with them because most of the times as students we were afraid because we don't know what they will say and with the like, I can say the history that we get when you are in year one. People tell you this one is difficult so when you are there it becomes difficult for you, when the lecturer comes, you run away and (.) when she asks you to do something you do it but not the way you could have done if the lecturer was not there.<sup>78</sup> (St-10-F-4)

Beck (1993) also identified pervading fear among nursing students during the initial

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<sup>77</sup> The word *recovering* in italics have been added to promote clarity of the sentence.

<sup>78</sup> The excerpt reveals that presence of the lecturer in the clinical setting affects the students' performance. The fear or anxiety resulting from such an encounter affects the students' rational thinking and this has been discussed in chapter eight under 'Emotional labour in caring-learning relationships on page 207 -208.

clinical placement. The study also provides evidence that interacting with patients was quite a challenge for some students when they were in year one. In view of this, learning to become a nurse involves learning to interact with patients and the excerpt below confirms this:

In the first place before I came to this institution it was very hard for me even to come closer to a patient. I lacked that courage and every time I see a patient I wouldn't even want to come closer (.) so I have learnt to be closer to a patient of whom I used to run away (St-8-F-4)

These findings concur with the assertion by Suikkala et al (2008) that entering into clinical practice is often a daunting or frightening experience for student nurses which requires them to learn to manage strong feelings and develop personal relationships with patients. Christiansen and Jensen (2008) also reveal that inadequacy in communicating with patients is a common problem among students.

Learning to become a nurse involves learning to work as a nurse both during a day and a night shift. The study reveals that substantial learning takes place during a day shift compared to a night shift because there is no clinical supervision at night and clients also sleep. However, exposing students to night shifts orients them to what happens during the night and prepares them for their role as future nurses. Some of the students expressed the following sentiments:

The night duties are fine clinically as long as there is supervision. It doesn't make sense to deploy students there and no supervision because as long as you are a student you are motivated with clinical supervision. At least you are kept awake for supervision. (.) If they are training us to be doing the night duties that's fine just to have the experience of how it feels like to be on the night duty. But otherwise as learning is concerned ah there is quite little learning (St-28-M-3)

I think night duty is done only to make us become acquainted to what happens (.). But otherwise much of the learning takes place during the day not during the night (.) because it's the time when most of the patients demand a lot of attention than during the night yah. (St-29-M-3)

I can say we don't learn during night duty maybe if an emergency comes then we can learn something (.). And I think if you really want to learn something it's during the day, if you miss the day then you will never learn anything (St-24-F-3)

Yazici (2010) reflects results of a descriptive study which was conducted to evaluate a midwifery programme at a Turkish university and the findings reflect students' perceptions regarding night shift. The study portrays both positive and negative opinions regarding a night shift. The Turkish students indicate that the night shift is important in preparing them for their job which is consistent with what the students in this present study expressed. Being midwifery students working during a night shift enabled them to meet their programme requirements in terms of number of deliveries to accomplish. Whereas night shift seems to be significantly beneficial to midwifery students, the findings in this present study suggest that night shifts are not as beneficial for students pursuing a general nursing programme. However, some of the concerns that the Turkish students raised are similar to what the students who participated in my study mentioned. For example, the absence of faculty members during a night shift appears to be a concern for both Turkish and Malawian students.

Some of the study findings portray lack of commitment and concern and some unprofessional conducts among some of the nurses. For example, students reported of qualified nurses sleeping during a night shift and that some of the nurses shout at patients and some of the students had this to say:

But there were other nurses that you actually say this person how did she manage to become a nurse? (.) They were just there to fulfil their job as a nurse but not to have personal relationship with clients. They could shout to a patient on a simple thing.

And those nurses who like shouting, most of the times clients are in pain either emotional, psychologically or physical pain, real pain. (.) But you will find that other nurses when they are asked even if it's a simple matter that they would have just said yes or no, they will start shouting. Those nurses they don't do good to the clients because they just add pain on them.

sometimes you are on day duty and the nurses coming on night duty, they could even talk as if it's a good thing that when they want to have a peaceful night duty they will just minimise all the litres (*flow rate for intravenous infusions*)<sup>79</sup> (.) so that they should last the whole night up to the morning,

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<sup>79</sup> The phrase flow rate for intravenous infusions in italics have been inserted to promote clarity of the sentence

and to them you could see that they felt as if there is nothing wrong with it.

This has implications on role modelling because such nurses constitute bad role models to students and they can negatively impact on their professional socialisation. There is evidence that sometimes students emulate some of the unprofessional conducts and the study reflects incidents in which students were also found sleeping just as the nurses did and this is illustrated in the following excerpt:

Of course there was a certain time I was on night duty so we slept in the office. (.) Unfortunately the nurses working with us on that night were also lazy, they locked the door around 10:00 so we also got motivated and we also actually slept and then (the lecturer) came around 2:00am. (.) As we went into the ward we found all the litres which were running had dried up (.) some patients were given metronidazole intravenously but were still hanging but had run out. There was blood which we administered we just took vital signs but we never recorded them. All these bad things (lecturer) was furious (St-28-M-3)

The excerpt reveals that students slept on a night shift just as the nurses were role modelling and the patients were left unattended. Although this could be attributed to poor role modelling, nevertheless, it conveys a lack of commitment to care among some of the students. Davies et al (1996) also reports of students 'picking up bad habits' in practice settings.

The study findings reveal how KCN students learn in the clinical setting. In the first place, learning is usually guided by objectives which the student plans to achieve each day. The objectives are normally documented in a reflective log and the student works towards achieving them. However, incidental learning also takes place depending on what students encounter during the clinical placement. Some of the students had this to say:

If I am going to the clinical area the first thing is that I have objectives. (.) Yes I am going to manage other conditions but also I will make sure that I achieve my objective (.) But also even though you have your own objectives but it happens that when you are there you also find another interesting case (.) you are going to follow that case (.) in the end you are also going to have a certain experience. (St-1-F-4)

When I have planned that today I want to achieve this objective (.) and by

the end of the day I don't achieve the objective as I planned, it becomes something that I get disturbed. Ah I planned to do this but then it has not worked, I'm I the problem or I look at the setting. Ah what was the problem? (St-8-F-4)

There is extensive use of reflective logs but this is mostly just for documentation of learning objectives. Although it is a requirement for students to have them, sometimes students do not use them and the students I interviewed complained of lack of proper guidance from the lecturers on how to document in the reflective log. Some students also mentioned that making entries in the reflective log can be boring because there is considerable repetition and this is one of the factors which cause the students to stop using them. It is also apparent from the findings that the reflective logs are not used to promote reflection<sup>80</sup> and some of the students I interviewed indicated that they are not familiar with reflective learning and this is illustrated by the following voices:

To say the truth the only time I used a reflective log is during psychiatric experience we didn't know what a reflective log is we only we were writing objectives, (.). I have been to Norway that's where they taught me about reflective log. (St-14-F-4)

It's only a six weeks allocation but after three weeks you would find yourself that you've done everything that is in the objectives then afterwards you will just be repeating those procedures, you will just be repeating. (.) It is boring writing in the logbook because all those things you have already done yes. (St-23-F-3)

And sometimes it becomes boring early in the morning or maybe in the evening you say I should write the objectives for tomorrow. The plan is still the same (.). Looking at the objectives it's the same. I think there are contradicting ideas from lecturers. This one will say follow this, the other one will say follow this. They need to come to a consensus. (St-7-F-4)

These findings are consistent with Burrows (1995) who indicates that younger student nurses tend to cite lack of time, boredom and perceived limited usefulness as reasons for not completing journal entries. Burrows further states that many of the nursing students 'religiously' maintain their journal entries during the initial placements but they soon tire because they feel they are writing 'nothing new' and

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<sup>80</sup> These issues have also been discussed in chapter eight where a conclusion is made that the learning which takes place among KCN students is largely non-reflective on pages 174-175

this is similar to what KCN students do.

The study findings also illustrate how students' learning is maximised in some clinical settings. For example, one of the students gave an account of her experience at a surgical ward where she felt her learning was enhanced because they were allowed to follow a patient from the clinic where admissions and follow up are done, to the ward where the patient is taken care of both pre-operatively and post-operatively. The student also indicated that they were even allowed to go to theatre just to observe even though they had not yet done theatre nursing. The student had this to say:

At (name of hospital) I learnt a lot from the surgical department. I liked the team, they were very cooperative. (.) I remember we used to have surgical clinics. They were telling us to make a schedule to say how many are going for the clinic and how many will be staying in the wards, (.) So they will make sure you see the patient from the beginning when they are presenting with the condition. Then they will also teach you to say this is how the condition presents, this is how we are going to manage this condition. These are the diagnostic tests we are going to do. And then you are going to have the patient in the ward; you are going to manage the client pre-operatively and even post-operatively and the client will be discharged. Now you are going to meet the same client in the clinic where now you are able to see alright, this is how he was presenting, we managed the client in this way and after discharge this is how the patient is presenting now. And not only that, they were also giving us a chance; by then we had not done theatre nursing but they were giving us a chance to say you should come and see in the theatre how we operate (.) that also makes it so easier for you to manage the client post-operatively because you know what has been done in theatre. So that made me to learn a lot and like the placement because I was learning a lot. (St-27-F-3)

What is described in the excerpt above is similar to managing placement learning using patient pathways<sup>81</sup> (Hutchings and Sanders 2001; Pollard and Hibbert 2004). A patient pathway is a journey or route the patient may take in the course of being treated. This exposes the student to a variety of professionals and departments who contribute to patient care (Pollard and Hibbert 2004) and enriches students' learning.

The study also reflects students' perceptions on their preparation for the nursing

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<sup>81</sup> A discussion on patient pathways is also reflected in chapter nine under 'Innovative clinical supervision.' on page 235.

career. The students I interviewed felt that they have been adequately prepared for their role as future nurses and they can be able to function independently when they qualify and this is illustrated by the following voices:

I think it's good it's great; we know most of the procedures. Like now when they post me to paediatric ward I will be able to handle the children there. (.) I have been to most of the wards: the gynaecological ward, the medical ward, the surgical ward. When they post me and put me in any of these wards I will be able to manage the wards (St-24-F-3)

Despite that I have learnt using limited resources, maybe an environment that nurses are not there but I have managed to learn from there. It's not that I have managed to learn just because of myself but because of my fellow students who were assisting me through out. I have managed to learn somehow despite the shortage and improvising. (St-2-F-4)

However, feelings of inadequacy are also evident and students indicate that the lack of resources has been the main cause of such a setback leading to deficits in some nursing skills. In addition minimal supervision by lecturers is also responsible for the perceived skills deficit. Students reported that in the absence of lecturers they learn short cuts in the clinical area which do not constitute ideal nursing practice and some of the students had this to say:

I have been adequately prepared but then we might have some deficits yah, but the thing is we have been prepared. (Ku-8-F-4)

I feel like most of us we have deficiencies in doing some of these procedures because our lecturers do not spend considerable time at the clinical area (St-13-F-4)

Literature also reflects skills deficit among students within the British nursing education but the causes of such deficiencies are different. For example, Luker et al (1996) cited by Bick (1999) claims that student nurses under the current British nursing education system usually qualify with less experience of the clinical situation and potentially with some clinical skill deficits because they spend less time working in the hospital environment than the students who qualified under the apprenticeship model of training. Similarly, Dolan (2003) also reports of students qualifying without achieving acceptable competence due to emphasis on achievement of individual competencies which hinders students from gaining a holistic experience of care.



## 5.2. Student support: Encounters with lecturers

The study reveals that there is minimal clinical supervision by KCN lecturers and their visits to the clinical area are quite sporadic due to other role preoccupations. Sometimes students do not see a lecturer for over a period of two weeks and there is even evidence that some students do not see a lecturer for the entire clinical placement. Clinical supervision is even more erratic when students are allocated to hospitals in other districts which are far from the two College campuses<sup>82</sup>. The following extract eloquently captures concerns which were raised by most of the students:

Supervision by our lecturers is not all that good (.). Sometimes you would stay maybe two weeks without a supervisor coming; when you ask, eh she went for a seminar or she is somewhere (.) if she comes, maybe she will come only in the morning, and she has two wards to supervise (.). And sometimes you would be in an allocation maybe for six weeks and not have that relationship with your supervisor. Maybe you could actually ask yourself I don't think this supervisor even knows my name. Because maybe she will just come then meet you in a group and discuss something but not having that personal like a lecturer and a student, like one to one whereby maybe you have other problems that you cannot talk about them in a group (.). But when you have that relationship I feel it's good. And in our supervision that was not much common (St-10-F-4)

KCN lecturers spend less time in the clinical setting with students which is also echoed by others in studies conducted elsewhere (Clifford 1993; Davies et al 1996; Forrest et al 1996; Griscti et al 2005). Consistent with previous research, the study reveals that excess workload or other work commitments hinder nurse lecturers from fulfilling their role (Crotty 1993; Davies et al 1996; Forrest et al 1996; Griscti et al 2005; Gillespie and McFetridge 2006; Barret 2007; Meskell et al 2009). Consequently group supervision becomes the only feasible approach but the students' view is that after the group session the lecturer should have time with each individual student. Other studies in literature also reflect team supervision (Saarikoski et al 2007;

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<sup>82</sup> Kamuzu College of Nursing has two campuses, the main campus is in Lilongwe and Blantyre has a satellite campus and sometimes students are either allocated at Zomba Central hospital and sometimes Mzuzu Central and these two hospitals are located away from the two campuses. See Map of Malawi on page 11

Papastavrou et al 2010). The study clearly indicates that there is need for regular and frequent clinical visits by lecturers and this bears resonance with other studies in literature (Koh 2002; Brown et al 2005).

As reflected in the excerpt above, the student observes that good lecturer-student relationships are rare and also mentions of wondering whether the nurse lecturer knows her personally by name. Nylund and Lindholm (1999) also reflect similar findings in that the students who participated in their study expressed a wish to be treated as individuals by the supervisor remembering their names. The intermittent clinical visits by lecturers hinder them from knowing students personally and at the same time deter students from becoming acquainted with them. Consequently, students perceive them as a threat when they visit the clinical setting and they avoid them because their presence induces stress and the following excerpt illustrates this:

And most of the clinical allocations we don't have much supervision the lecturers come maybe once a week and maybe once in two weeks so when they come instead of maybe supervising it's like they a threat or a stressor to the students (St-14-F-4)

The study illustrates the lack of lecturer-student relationships<sup>83</sup> and the student's concern whether the lecturer knew her personally also lends support to this assertion. Such a concern also substantiates that the lecturer-student relationship is important in facilitating clinical learning and these findings are supported by previous research (Lee et al 2002; Lofmark and Wikblad 2001; Shen and Spouse 2007).

Although this present study largely portrays lack of lecturer-student relationships, students' narratives indicate that presence of the lecturer in the clinical setting makes them to feel confident and encourages them. The nurse lecturer's questioning and the assignments that they give motivate students to learn. The anticipation of the lecturer's coming also motivates students to take care of patients so that they will have something to report about to the lecturer. Lecturers also encourage students through positive feedback and some of the students made the following comments:

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<sup>83</sup> Issues on student-lecturer relationships are further discussed in chapter eight under 'Emotional labour in caring-learning relationships' on pages 205-206

When the lecturers come you feel confident. They encourage you; they tell you you've done this very well that is good. You've done this wrongly next time I want to see how we can go about it (St-2-F-4)

Clinical supervisors, though they were not coming frequently, but at least they were there to help us with some of the things. Sometimes you would do something so that at least like every day I should be taking care of a patient so that whenever my supervisor comes I should be able to present something (.). It was really like making you to be motivated to do something really good that day. (.). And their coming to the ward was nice it was really encouraging (St-24-F-3)

This illustrates that there are some positive encounters between KCN lecturers and students and confirms that some of the lecturers significantly contribute to students' clinical learning. The study also suggests the need for student-faculty relationships where lecturers should provide support to students on both academic and personal aspects of the student's life and the following excerpt illustrates this:

I had a lecturer who would always look at my strengths and my weaknesses and assisted me to work on my weaknesses. the whole interaction was so holistic in terms that she did not only look at my academic aspect but she was also looking at the personal aspect which in most cases sometimes most lecturers maybe take not into account; they only look at the academic aspect. (St-5-M-4)

This is consistent with what Gillespie (2002) interprets as 'connected relationships'<sup>84</sup>. 'According to Gillespie, 'connected relationships' focus on personal and professional components whereas in 'non-connected relationships' the focus is only on work and there is no acknowledgement of personal aspects. I would construe 'connected relationships' as occurring where the lecturer focuses on both personal and academic aspects of the student and 'non-connected relationships' as where the focus is only on academic aspects. Students sometimes encounter personal problems and they do not know who to talk to and they become emotionally affected. As already mentioned,<sup>85</sup> these personal problems can hinder clinical learning and sometimes the consequences can be fatal leading to student failure. During such

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<sup>84</sup> 'Connected' and 'Non connected' relationships discussed further in chapter eight under 'Emotional labour in caring-learning relationships' on pages 205 - 206

<sup>85</sup> See discussion under 'Stressful experiences' on page 94 - 95

situations students need lecturers who can listen to them and support them and the student had this to say:

Sometimes you may have some problems maybe at home or some other issues. Sometimes you may become disturbed, you may not concentrate (.) you become confused and you don't know what to do and who to talk to (.) some of them sometimes are sensitive issues. And they need someone maybe to listen to your story. (St-5-M-4)

Besides personal problems, some of the challenges which students encounter during clinical placements also require that lecturers should offer them emotional support. In some cases such support has been quite effective in averting possible attrition.<sup>86</sup> The study illustrates that students require caring faculty<sup>87</sup> because of the personal problems and the challenges they encounter during clinical placements. This is consistent with Beck (1991) who identified that student caring experiences with faculty range from personal problems to academic and clinical matters.

The study reflects students' perceptions on the approaches which lecturers use during clinical supervision. Most commonly when lecturers visit the clinical area, they just observe what students are doing. For example, a lecturer might find a student performing a procedure. The lecturer will just observe and only intervene when the student is making a mistake. Students are quite critical of this approach. They prefer lecturers who work with them and not those that just observe. KCN students prefer that lecturers should engage in practice based teaching through provision of 'hands-on-care' and this is strongly expressed in the excerpts below:

The other problem I have found, (.) most of the lecturers here they go into the wards but they don't do what they teach the students (.) they will just stand and say what are you doing? No do this like this, do that like that. (.) I don't like that, I would rather be there doing them alone than somebody standing on my back and saying do this and do that because I assume they are supposed to demonstrate. We are supposed to work hand in hand. (St-28-M-3)

It appears some lecturers do not demonstrate the procedure even when they see that

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<sup>86</sup> See discussion on stress following death of a patient in chapter four on pages 93 which reflects how a student was blamed for 'killing a patient.'

<sup>87</sup> Caring faculty has been discussed further in chapter eight under 'Emotional labour in caring-learning relationships' on page 206

the student has performed it unsuccessfully. They just advise the student on what to do and students are also quite critical of this. Students do not like being corrected verbally when they know they have failed to do a procedure correctly. The study indicates that this is one of the areas where the lecturer should teach the students through hands-on-care as this helps them to gain mastery of nursing procedures. Merely correcting a student verbally without a demonstration may not suffice and these sentiments are strongly expressed in the following excerpt:

Because most of the times they will just come, (.) you haven't done it correctly, next time ah do it like this, like this. It's like the same theory that we had in class, but in the hospital I feel the supervisor has to do hands-on so that we can see. Because if you have failed to do the wound dressing while you learnt in class that means there is something that is missing that at least if you visualise then you will remember. (St-10-F-4)

Students repeatedly pointed out that lecturers should teach them through provision of direct patient care. This motivates them to learn and they value such clinical learning encounters. Through such a collegial working relationship, lectures can be in a better position to work closely with students, identify their strengths and weaknesses and be in a better position to help them to improve. The following extract confirms this:

When the supervisor comes to the ward and we work together (.) I can say the supervisor will have enough time to observe you, to know your weaknesses and strengths (.) they know how to help you to improve (St-16-F-3)

The view that lecturers should teach KCN students through hands-on-care lends support to Webster (1990) who contends that the teaching of clinical skills is an inherent responsibility of nurse teachers. However, it appears there is less support for this position in literature. Previous research conducted in the UK reflects that such a mode of teaching by nurse teachers is considered disruptive, unrealistic and frustrating (Crotty 1993; Elliot 1993; Forrest et al 1996 and Corlett 2000). The only surprising thing is that what is perceived as disruptive and unrealistic is what I would construe as comprehensive care. Forrest et al (1996) and Corlett 2000) reflect excerpts from students who participated in their studies and these indicate that the nurse teacher and the student spent hours providing care to one patient. If the patient needed such care, then providing it should not be seen as frustrating. Carlisle et al

(1997) investigated the clinical role of the nurse teacher within the project 2000 framework and the study participants perceived it not to be probable that nurse teachers would work with students in providing direct patient care, this was perceived to be a probable role for clinical nursing staff. Forrest et al (1996) also reflects students' views of the clinical role of the nurse teacher whereby the students valued the 'support role' rather than the 'teacher role' and the latter was perceived to be a role of clinical nursing staff.

The divergent opinions between the Malawian and the British students who participated in the above cited studies could be attributed to differences in the way clinical nursing education is managed in the two countries. It appears students within British nursing education are satisfied with the teaching support they obtain from mentors or clinical nurses in general which explains why they may not appreciate the teaching by the link lecturers or other designated faculty members. Two issues emerging from my study explain why the Malawian students prefer that lecturers should teach them as opposed to clinical nurses. Firstly, there are concerns over the academic credibility of some clinical nurses because the majority of the practicing nurses in Malawi are nurse technicians/enrolled nurses. Some of the registered nurses who do not possess a bachelor's degree also undermine themselves feeling that they cannot be in a position to teach students pursuing a Bachelor's degree. Some of the students expressed the following sentiments:

In some places where I found it difficult to learn they were saying, I am a student pursuing a Bachelor's degree in nursing and the personnel were saying I am a holder of a certificate I don't think I can teach you (.). If you have problems, maybe you can consult someone else who can assist you. So there was such a conflict. (St-8-F-4)

There are other nurses who are having a diploma in nursing and (.) we are having a degree in nursing so some of the nurses actually say ah you people you are higher than us you are going to have a degree in nursing so they don't want to teach us. (.) So most of the times they just leave it to the nursing in charge that has a lot of work, I mean the nursing in charge cannot teach a group of ten, fifteen students at once.. (St-26-F-3)

What is portrayed in the above excerpts is an honest opinion of some of the nurses

and does not signify negative attitudes<sup>88</sup> which other nurses display towards KCN students. Wilson-Barnett et al (1995) reflect similar findings in that some of the nurses who participated in their study had negative opinions towards supporting students during clinical placement because they lacked appreciation of what they could offer. Davies et al (1996) also reflects doubt over staff nurses' academic credibility. Their findings reflect dissatisfaction in relation to the extent to which nurse practitioners were prepared for their role in student learning.

Secondly, the other factor responsible for the divergent opinions has to do with dissatisfaction among KCN students with how some of the qualified nurses in Malawi teach. Students spend more time in the clinical setting with nurses be it enrolled/nurse technicians or registered nurses and they learn from them as they observe them performing procedures. Students expressed dissatisfaction with the way the nurses perform the procedures and the following voices illustrate this:

Due to shortage of staff and may be due to shortage in the number registered nurses, the type of learning that we get from these enrolled nurses leaves a lot to be desired because they are these nurses who do most of the short cuts (St-4-M-4)

A lot of us we learn the things from other nurses most of them they don't do the procedure rightly as it is written in the books. But when a lecture can come and you observe really we learn the real way of doing it. But because they don't usually come (.) we have deficiencies in doing some of these procedures (St-13-F-4)

You just learn maybe through other nursing officers who for sure because of the many patients most of the procedures are done non procedural (St-12-M-4)

The above issues therefore explain why KCN students prefer that lecturers should teach them in the clinical setting through direct patient care. When a lecturer purely assumes a role like that of an 'observer' simply asking students questions and never wanting to demonstrate some of the procedures, students begin to question the lecturer's clinical competence and the excerpt below attests to this:

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<sup>88</sup> Some of the nurses openly decline to teach KCN students because they are pursuing a bachelor's degree and this is a consequence of negative attitudes which some of the nurses display towards the students. See discussion under 'Student support: encounters with clinical staff' on pages 124 - 125 and under 'Emotional labour in caring-learning relationships' on pages 199 - 201

So I feel if the supervisors if they do something, it has much meaning to a student. Because sometimes you say that supervisor just says do this, do this I am not even sure if they know the things that they are saying maybe they just have the theory but at least if you see that they also know then you also say eh, I will also have to know because if she knows and she comes and I don't do it correctly then it will be a problem (.) (St-10-F-4)

These findings draw to our attention the issue of clinical credibility for nurse lecturers and literature is replete with debates to this effect. In the UK the transfer of nursing education to institutions of higher learning led to concerns about the adequacy of clinical nursing education (Mallik and Aylot 2005). This became a concern because with nursing being offered within tertiary education, students would have reduced time for practice as opposed to the amount of time that was allotted for clinical practice during the traditional apprenticeship model of nursing education. Therefore, concerns were expressed regarding the clinical competence of the project 2000 graduates and this led to a recommendation that Nurse Lecturers should have recent practical nursing experience to maintain their clinical credibility and competence (Barret 2007). Debates therefore followed on whether nurse teachers should engage in clinical practice as a way of maintaining their clinical credibility or not (Fisher 2005). With clinical practice being seen as a way enabling nurse teachers to be aware of the clinical realities (Cave 2005) so as to be able to create reality in their teaching (Bently and Pegram 2003). It appears such debates have been resolved within nursing education in the UK and presently the mentor takes an active role in supporting students' clinical learning and there are various models of clinical supervision which reflect nurse lecturers' involvement in clinical learning. This has been stream lined to a few nursing faculty taking part in supporting students' clinical learning and literature reflects various titles for such lecturers some of which include link lecturer (Koh 2002), clinical education facilitator (Lambert and Glacken 2005).

This present study indicates that the lecturers' credibility and competence could be a concern among student nurses at KCN and other studies conducted elsewhere also reflect the problem of nurse teachers' inadequacy (Corlett 2000; Mangena and Chabeli 2005; Cheraghi et al 2008). Elliot and Wall (2008) attributes this to scholarly



activities such as writing for publication. In addition, maintenance of clinical contact may not be a priority because clinical practice is not the criteria for promotion (Ward 2001) and even where this could be the criteria, the workload involved is likely to be quite enormous so that aspiring for promotion through such a route would be a daunting exercise.

The approach to clinical supervision significantly determines the success of the student-lecturer interaction in the clinical setting. KCN students prefer that lecturers should be friendly and approachable. This is important firstly because it makes the students feel free to ask questions and secondly, some of the lecturers whom students encounter at the clinical area are not the ones who teach them in class and it becomes difficult for students to interact with them because they are not familiar with them. Lecturers should have welcoming and smiling faces and should greet students as this makes them to relax and to perform procedures calmly. On the other hand, a lecturer who approaches students with a gloomy face and does not even greet them but simply 'fires' questions threatens the students and they begin to avoid the lecturer. Students also resent lectures who only point out their weaknesses and if there is need for correction students prefer that it should be done in a way which maintains their self-worth. The following voices<sup>89</sup> illustrate some of these issues:

I consider a lecturer when you are in the ward not to be like a watch dog (.). When a lecturer is just pointing out areas where you haven't done right, is just saying (.) up to this time you are in this year but you can't even do this (.) it discourages a learner. But when they are encouraging you to say you know what, I have been observing you; I can see that you are able to do this, (.) I have also noticed that you've got these areas of weaknesses which need improvement and if you can do this (.) you are going to make a good nurse. That encourages someone (.) So the approach itself is what can make you to say ah do I go on? (St-27-F-3)

When an individual is having a smiling face or a welcoming face that person is likeable by a lot of people, so it's the same with the supervisors. Let's say they've found you at the ward and they are coming with a gloomy face you start fearing (.) but if she comes and she smiles at you, she greets you then

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<sup>89</sup> The excerpts confirm the need for lecturers to engage in emotional labour in order for them to display a countenance which conveys a caring attitude to students. There is emphasis on being friendly, having smiling and not gloomy faces. All this confirms that even in nursing education it is the 'little things' that matter. Merely greeting a student makes a difference. See discussion on pages 209

you tend to relax, you do things calmly (.) because that supervisor is so welcoming. (.) She asks you what have you done (.) gives an encouragement on what you have done and tells you the shortfalls, that supervisor encourages a lot. (St-23-F-3)

we are youth so they should be youth friendly not coming there like some come, as if they are already angry with something else (.) you just run away<sup>90</sup> (.) But some lecturers come while smiling; even greeting you but some lecturers they don't even greet you (laughter). So they should also be smiling at us, and they should be youth friendly yah (St-24-F-3)

These findings reveal that lecture's attributes are vital in facilitating clinical learning and some of the existing literature supports this (Fowler 1995; Jacono and Jacono 1995; Shen and Spouse 2007; Cheraghi et al 2008). Showing personal interest in students appears to be one of the essential clinical teaching behaviours and this is also reported by other researchers (Hughes 1992; Li 1997; Nylund and Lindholm 1999; Neary 2000; Koh 2002). Griffith and Bakanauskas (1983) indicate that demonstrating interest in the learner may facilitate a positive self-concept and enhance cognitive abilities. Levette-Jones et al (2007) reveals that welcoming, accepting and supportive clinical educators increase student capacity and motivation for learning.

The study findings also reflect some approaches to clinical supervision which are characteristic of bad educators. These include what some of the students described as 'policing,' shouting at students and correcting them in an embarrassing manner and these are lecturer behaviours which hinder clinical learning. A policing approach involves a lecturer asking questions while the student is in the middle of performing a procedure which gives the student a feeling of being interrogated and intimidated. The following excerpts reflect some of the sentiments which students expressed:

Sometimes the other clinical supervisors may make learning so hard in a sense that, for example, you are doing a procedure on a client. The clinical supervisor would come in the sense like policing you. So you are definitely scared, you cannot perform that procedure as it is expected just because you are anxious<sup>91</sup> (.) The policing is being done in the sense that you are doing

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<sup>90</sup> This reflects some distancing or detachment strategies which students employ to protect their emotions and this is discussed in chapter eight under the theme 'Emotional labour in caring-learning relationships' see discussion on page 207

<sup>91</sup> The impact of severe anxiety or stress on students' performance and rational thinking is discussed in

the procedure and the supervisor comes in, starts asking you questions. (St-20-F-3)

I think supervising is not policing us. I believe that if you are there just to intimidate or just to question a student I think it will not be good but we should work hand in hand, we should work as a team. (St-21-F-3)

The policing or interrogative approaches make the students' learning hard because they become scared and anxious and cannot perform the procedure as is required. Students resent being shouted at and being corrected in the presence of patients because it makes them to feel embarrassed, patients lose trust over them and students become demotivated and they do not learn because they are preoccupied with negative feelings. Some of the students had this to say:

Some supervisors will actually talk to you at that patient's bedside with the patient there listening and the patient will know that this student didn't do the right thing. (.) And the next time you come they don't have that trust in you and even you, you are demotivated (.) you don't learn because you have those negative feelings; and when that supervisor comes again you will not want to go and interact with that person (St-10-F-4)

But there are some lecturers who when they come to the clinical area, they would shout at you while you are at the patient's bed side and say, ah no we don't do like that you want to harm the client! So when clients hear that, they don't trust you anymore then when you go you feel humiliated<sup>92</sup> and you don't like working anymore (.). So those lecturers have discouraged me who shouted at me whilst I am doing a procedure (St-23-F-3)

Hughes (1992) also reflects similar findings and indicates that coping with feelings of anxiety and humiliation evoked by such encounters necessitates the expenditure of substantial personal energy. Presumably this is the reason why after such an encounter students tend to dread interacting again with such a faculty member and they feel demotivated and do not want to work again. Although students may be wrong and sometimes it could be that what they are doing could be harmful to the patient, the study reveals that students still prefer to be corrected amicably and not to be shouted at. The following excerpts reflect how students prefer to be corrected when the lecturer identifies that what they are doing could be detrimental to the

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chapter eight on pages 207 - 208

<sup>92</sup> Humiliation of students is discussed in chapter eight under the theme 'Emotional labour in caring-learning relationships' see discussion on page 208 - 209

patient's life:

There are times whereby what the student is doing can do harm to the patient. So I prefer to say when the supervisor sees that (.) the supervisor should tell the student to relax while she takes over (.)after finishing the procedure go aside and you discuss rather than just, you made a mistake! You would have killed the patient! This is not how you do it! That person feels bad, it brings shame and embarrassment and mistrust in the patient that this one would have killed me. (St-8-F-4)

I feel lecturers like sometimes should not be too emotional<sup>93</sup>, when you have done something wrong they should call you somewhere and then you discuss the issues to you thoroughly for you to understand that thing. (St-13-F-4)

Simukonda and Rappsilber (1989) also obtained similar findings in that the students who participated in their study reported of being corrected in the presence of patients and being shouted at by the lecturers. This was a study which was conducted among male students at KCN and this implies that almost twenty years down the line the approach to clinical supervision is still the same. Nylund and Lindholm (1999) also reflect similar findings as some of the students who participated in their study reported that they felt hurt and humiliated through clinical supervision and the students further expressed that a supervisor should not slander a student even in the case of failure to accomplish a task. These findings illustrate the importance of the lecturer's calm disposition and effective communication skills and Kelly (2007) also reflects similar findings in that the students who participated in her study valued a teacher who is respectful and calm.

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<sup>93</sup> Some lecturers become emotional when a student has made a mistake and this explains why they should learn to manage their emotions. This is further discussed in chapter eight see discussion on page 208 - 209

### 5.3. Student support: Encounters with clinical staff

The study findings reflect that some qualified nurses and other health care providers such as doctors and clinical officers have been quite instrumental in facilitating clinical learning for KCN students. As already discussed, nurse lecturers are not always available and their clinical visits are intermittent and of a short duration. Therefore, clinical staff provide most of the support which students require during the clinical learning experience and one of the students had this to say:

I can say that the clinical staff, (.) there are the ones who have facilitated much of my learning eh, (.) because most of the times they were the ones who were readily available (.). So I would say they have contributed quite a lot to my learning; and also I can add some doctors and some of the clinical officers in the Central hospitals. (St-10-F-4)

This is in agreement with previous research (Windsor 1987; Dunn and Hansford 1997; Attack et al 2000). KCN students value the teaching input of clinical staff and a study by Jackson and Mannix (2001) also revealed similar findings. However, this present study also indicates that just as is the case with lecturers, clinical supervision by clinical nursing staff is equally not adequate. Students reported variable levels of commitment by clinical nursing staff towards facilitating clinical learning. In some clinical settings nurses are willing to teach students whilst in other settings students lack support. This said, clinical settings differ, some provide positive clinical learning environments while in other settings the atmosphere is bad and learning is hindered. Some of the students expressed the following sentiments:<sup>94</sup>

Ah what I saw basically was you could see that in other settings you were able to find resources, and you were able to find people willing and who would always direct you. And in these settings you would see that learning was always taking place because you could always find support. (St-5-M-4)

There were other nurses that were willing to teach and others were not. Others were just shouting at you so it would depend. If the nurse was a good one you would easily learn and you would easily get along in the ward and you learn. But if the nurses, because there were some who would not even

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<sup>94</sup> The issues of student-nurse relationships which the excerpts convey are further discussed in chapter eight see discussion on pages 199 - 202

greet you when they come so it even becomes a problem for you to learn even to ask because you become afraid even to ask so you don't learn from them. (St-9-F-4)

I would say these settings have been challenging at times; I will start when I was in first year. I found it challenging because when we go into the clinical area we found those that are already qualified. Now the challenge is you go there as a student, you've learnt in class, you have the knowledge (.). Now you go to the clinical area where you need assistance from the already qualified staff and these staff are not willing to help you such situations I found them challenging because you work under fear to say if I do this maybe I will kill this patient You need guidance, you need assistance but those that are supposed to assist you are not willing so it really becomes a challenge. (St-7-F-4)

The fact that clinical settings vary as CLEs is consistent with previous research (Fretwell 1980; Ogier 1981; Orton 1981; Windsor 1987; Smith 1992; Forrest et al 1996; Chan and Ip 2007; Levette Jones et al 2009). Langan et al (2003) reveals that clinical nursing staff may have a positive or a negative response to the role of facilitating student learning and this is consistent with the findings in this study. Similarly, Brammer (2006) identified that there are variations in which registered nurses understand their role with students and that as a consequence of this; students may have positive or negative learning experiences. Polifroni et al (1995) also indicate that some of the clinical nurses do not consider facilitation of clinical learning as an integral part of their role. The pre-existing problem of nursing shortage in Malawi coupled with the unwillingness of some nurses to teach students implies that few clinical nurses are committed to clinical teaching.

The study identifies some possible reasons why some clinical nurses decline to teach KCN students. One of the reasons has to do with the fact that KCN does not pay them. The issue of payment is associated with the use of clinical nurses whom the College recruits as mentors and these are normally paid. However, the study reveals that this creates a problem because nurses who are not recruited become unwilling to teach students and the excerpt below reflects this:

some other nurses don't mind about students or whatever you are doing unless the College appoints (.) them and gives them money then the nurse is going to be interested in supervising you but in other wards where there is no nurse being given money, although the College tells them that we are

bringing students you have to supervise them but if they are not giving them money they don't actually supervise you (.) but if they are given money they usually supervise a lot. (St-14-F-4)

Students observed that some clinical nurses seem to have negative attitudes towards them and it appears this is the main reason why some nurses are unwilling to teach them. The nurses manifest the negative attitudes through a non-receptive disposition and also through derogatory remarks which they make mostly when students commence a clinical placement in their ward. The negative attitudes seem to be linked to the fact that KCN students are pursuing a Bachelor's degree, a qualification which most of the practicing nurses do not possess. The negative attitudes also seem to be associated with some preconceived ideas which some nurses have about KCN students and there is also evidence that negative attitudes are common in wards where none of the nurses is a KCN graduate. One of the students expressed the following sentiments:

Most of the nurses the moment we walk into a ward they have this perception that these KCN students think that they are going to be bosses over them in future and they think we have an attitude problem but we don't. (.). They call us theory nurses that we are only good at theory but practically we are not; which is bad. (.) They just have a bad attitude towards us (St-22-F-3)

Students perceive these negative attitudes to be a major hindrance to their clinical learning. They reported that in clinical settings where this is a problem, it makes their life in the ward to be very difficult and some of the students described it this way:

It is the attitude which hinders clinical learning (.) because if you are in an environment where people are not receptive. They don't accept you are there. They don't want to work with you, you cannot definitely learn from those people. So I take attitude as a very crucial thing. (St-2-F-4)

In other settings we have nurses that maybe don't like students in general (.) So when we are on duty with these nurses with bad attitudes or that kind of personality it is also a hindrance for us to learn because we don't usually do much and usually students resort to absconding<sup>95</sup>, they go to the hostel (St-14-F-4)

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<sup>95</sup> Absconding is one of the distancing or detachment strategies which students employ to protect their emotions when they are allocated in wards where the CLE appears hostile. See discussion in chapter eight on page 2201 - 202

When you ask them to help you with a procedure they will tell you to say I thought you are doing bachelors<sup>96</sup> you mean you do not know that at this level. It means you will just come out of that learning experience, that allocation without getting that experience because you will be afraid. (St-27-F-3)

Consistent with previous research, these findings illustrate that students encounter problems during clinical placements from nurses who have not had a university educational background (Hart and Rotem 1994; Dunn and Hansford (1997; Calman et al (2002) and the following excerpt confirms this:

The other problem we are facing is the differences in the cadres as the nursing officer and the nurse technician. Personally I do not blame those who graduated at a diploma level because by then we never had a degree in nursing. And now the profession is growing and that's when we are having nurses graduating at degree level. But the problem which is there is that many nurses do not just accept it. (St-27-F-3)

In common with Calman et al (2002) the study findings reveal that in clinical settings where one of the practising nurses is a KCN graduate, the students' experiences are more positive and one of the students had this to say:

In a clinical area where there is a KCN product like a nurse who has been at KCN we usually have a good relationship because she knows I have been at this school but in most allocations where we don't have a KCN product it becomes difficult because most of them I believe they have a negative attitude with students. I don't know from the past what happened but most of them they have a negative attitude so they don't like teaching the students of KCN (St-14-F-4)

It appears that the psychosocial atmosphere determines how students will conduct themselves during the clinical placement. Where the atmosphere is good and nurses are willing to teach students are always committed to their own learning, they are always punctual and they never want to leave the setting but where there are poor relationships, absenteeism and abscondment commonly occur. The following voices illustrate this:

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<sup>96</sup> The problem of negative attitudes seems to be linked to the fact that KCN students are pursuing a Bachelor's degree and these issues are further discussed in chapter eight. All this has its origins in lack of standardization of nursing education in Malawi. See discussion on pages 200 - 201



When you have all that good relationship with senior nurses in the clinical setting you always want to go back and work in that environment. You can't be late even during lunch time you are always on time, one hour you go. But when you have had a very bad interaction, you don't want to go back to that environment because you feel like you won't be in a good position to be helped. (St-5-M-4)

I would go to another setting where I would even find myself very uncomfortable (.) just too restricted. (.) But there were some settings where I wouldn't want to leave that setting, as if I would just be working there because of the friendliness of the people and their eagerness ah to teach me. (St-8-F-4)

These findings are echoed by (Levette-Jones et al 2009) who reveal that positive and supportive environments enhance students' motivation and enthusiasm for the placement. Consistent with previous research, the study illustrates the importance of nurses' attitudes towards the promotion of clinical learning (Napthine 1996; Nolan 1998; Jackson and Mannix 2001; Papp et al 2003). The teaching orientation and the nurses' attitudes towards students significantly influence the students' perception of the clinical learning environment and this is consistent with previous research (Lee and French 1997; Aghamohammadi-Kalkhoran et al 2011). The nurses' attitudes towards students determine whether students feel accepted or not and acceptance of students as learners is crucial in promoting clinical learning and previous research substantiate these findings (Nolan 1998; Cope et al 2000; Spouse 2001; Shen and Spouse 2007).

The study reveals that sometimes students are the ones who cause ward sisters or clinical nurses to have negative attitudes towards them because of the way they interact with them. This normally happens if students have preconceived notions that a particular ward sister is difficult based on what they may have heard through the grapevine. This negatively impacts on the student-nurse interaction and in turn the students lack support with clinical learning because of the poor relationship that ensues. One of the students expressed the following sentiments:

We had some problems with the in-charges because of our perceptions. The students who were ahead of us used to say such, such an in-charge is tough on students (.). As a result, our interaction with that particular in-charge or

that particular nurse was poor as compared to other areas where we were interacting freely. This affected our performance because we had no one to refer to. (St-30-M-3)

Although negative attitudes and poor relationships between clinical nurses and KCN students appear to be a common problem, some students gave accounts which portray some positive encounters they had with some of the clinical nurses and the following excerpts illustrate this:

We had in the (name of ward) a nurse in charge and this nurse in charge was so nice and we were always interacting (.) (.) Sometimes in terms of decision making she could call me, what do you think here? And it was like she was giving me power to think and at least I have potential, I can think, I can decide something for patients. So I had a special interaction with this nurse. (St-5-M-4)

There, there was a sister, I liked the sister because she was there for me we were working as colleagues where I was deficient (.) she could assist in every aspect. (St-11-M-4)

There was another nurse who encouraged me very much (.). She was pregnant by then, almost fully term pregnant but she could work very hard (.) you look at her; you wouldn't want to sit down. (.) She is pregnant instead of resting she was always on the move doing something for the patient and she could listen when the patient says I am feeling this she could understand. (.) That in-charge encouraged me so much that if all nurses were like her, nursing would have brought a good image to the outside people. (St-23-F-3)

The study reveals attributes of nurses which facilitate or hinder clinical learning. Acceptance of students as learners, friendliness, and openness to students, flexibility and being approachable are some of the positive attributes. Clinical nurses who promote clinical learning are knowledgeable; they teach and they demonstrate various nursing procedures to allow students to observe and later ask them to practice under their supervision. This allows students to perform procedures comfortably and confidently. Clinical nurses who are committed to their work motivate and encourage students to learn. Such nurses know their responsibility in the clinical area and they work alongside the students and do not just remain idle in the nurses' station. Student's accounts indicate that they prefer nurses who have a collegial relationship with them. Nurses who are always smart and put on a full uniform including a nurses' cap and epaulets also encourage students. Other positive attributes of clinical

nurses which students esteem highly include respect, politeness and love for patients.

The following excerpts illustrate some of these issues:

The clinical staff should be friendly, they should be flexible um and I feel the clinical nursing staff should be updating their knowledge on how to care for patients (.) Because when you are just coming in into this profession it's like you know nothing so it's up to somebody to guide you (.) but when the person who is helping you doesn't know (.) you will also not learn anything. (.) They should be flexible so that students are able to ask questions and ask about certain procedures. They shouldn't be too much emotional yah. (St-13-F-4)

Being friendly it's good because they welcome you to the ward and you are able to work freely. It's also nice when you are working with people who are like smiling at you (.) being friendly you work together not working with people who are just shouting at you, you feel like you can't work with them. (St-24-F-3)

Attack et al (2000) revealed that collegial relationship is important for students' learning and their professional socialisation. Likewise, Papp et al (2003) indicate that a good clinical learning environment is one where student nurses are regarded as younger colleagues. Clinical nurses who just delegate all the work to students and those that shout at patients discourage students. Consistent with previous research (Hart and Rotem 1994; Dunn and Hansford 1997; Shin 2000; Löfmark and Wikblad 2001; Chow and Suen 2001), the study reveals that relationships between students and clinical staff have a profound effect on students' clinical learning.

#### **5.4. Conclusion**

Despite the problems and challenges that students encounter in the clinical settings during their clinical placements, the study reveals that the clinical experience is indispensable and that the learning that takes place is quite substantial. The clinical experience helps to put what students learn in class into a proper perspective hence consolidating their learning. Students' clinical learning mainly involves learning to take care of patients with medical or surgical conditions and the acquisition of the various psychomotor skills required in the provision of patient care. Students also learn some professional values such as compassion, empathy and passion for patients through some experienced nurses whom they emulate as their role models. However,

the study also portrays the likelihood of students acquiring less than ideal practice through some of the nurses who conduct themselves in an unprofessional manner. Apparently this seems to be a common problem within most clinical settings in Malawi.

The study illustrates that there is inadequate student support during clinical placements by lecturers. Their visits to the clinical setting are quite intermittent and brief which hinders development of lecturer-student relationships. Consequently, the lecturer's presence in the ward is perceived by the students as a threat and it induces stress among students. This confirms that the student-lecturer relationships are central to the promotion and facilitation of clinical learning. Some lecturers tend to be impersonal in their approaches to clinical supervision and they employ what students interpret as 'policing,' or they shout at students or correcting them in an embarrassing manner in the presence of patients. Students resent such lecturers and they avoid them when they visit the clinical area. Despite the lecturers' role failure, students' narratives indicate that they have a great potential in facilitating clinical learning. Students become encouraged and motivated to learn through fruitful lecturer-student learning encounters. There is a resounding message from the students that lecturers should teach them through direct patient care failing which, they learn from what clinical nurses do, which does not constitute ideal nursing practice. The study also portrays students' perceptions of good lecturers. Students prefer lecturers who are approachable, friendly and those that approach them with smiling and welcoming faces.

The study also reveals that clinical personnel such as nurses and doctors contribute significantly to students' clinical learning. However, there are variable levels of commitment among clinical nurses towards the clinical teaching role. Some nurses are willing to teach students while others are not. Some of the reasons for the unwillingness to teach have to do with the fact that KCN recruits mentors from among practicing nurses and they are paid. Therefore, some of the nurses who are not recruited as mentors become unwilling to teach. The unwillingness is also attributed to negative attitudes which some nurses have towards KCN students.

Apparently this seems to be associated with the fact that KCN students are pursuing a Bachelor's degree which most of the practicing nurses do not possess. This leads to poor relationships between students and clinical nurses and this appears to be a common problem. In some clinical settings the CLE is hostile and oppressive such that students are shouted at. This is one of the reasons for absenteeism and abscondment which are reported among students. In clinical nursing education, students are believed to be masters of their own destiny and in view of this, in the chapter that follows I present findings which touch on student related factors in clinical learning.

## CHAPTER 6: STUDENT RELATED FACTORS IN CLINICAL LEARNING

*The student is, on the whole, master of her own destiny. S(he) selects learning from a wide variety of offerings, depends upon her peer group to a large extent. (Wyatt 1978, p. 269)*

This chapter reveals some significant insights into how students themselves facilitate or hinder their own learning. The study reveals that students play a significant role in the promotion of their own clinical learning and these findings lend support to the assertion that students are masters of their own destiny (Gray and Smith 2000). The Student's intrinsic motivation to learn appears to be the primary determinant factor of how clinical learning will progress. Extrinsic motivation is also a necessary prerequisite and it helps in the sustenance of the student's intrinsic motivation. Due to lack of support from both lecturers and clinical nurses, students become a resource to each other and the support they render to one another is quite substantial and it facilitates clinical learning. The study also reveals that the student's attributes determine whether learning will be facilitated or hindered. Some students are hard-working while others are lazy<sup>97</sup> and they influence each other positively or negatively depending on the attribute which is domineering among them. The results in this chapter are discussed under the following themes student motivation, shared learning and student attributes.

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<sup>97</sup> These are quite strong value judgments but they were made by the students themselves who constitute the 'insiders' where exploring clinical learning is concerned. See excerpts on page 144 - 145. I believe this is an aspect of reality which the study is unveiling.

### **6.1. Student Motivation**

The study reveals that student motivation is the main determining factor of clinical learning and both intrinsic and extrinsic motivations are essential but the former takes primacy. Intrinsic motivation has to do with what an individual wants needs and desires and it is deeply grounded in ones values and feelings while extrinsic motivation is an attempt by someone else to make an individual want to do something (Weiss 2000). Thus with intrinsic motivation the drive to learn is inherent in the student while at the same time students can be motivated to learn by external sources. Students' accounts indicate intrinsic motivation significantly influences clinical learning and the following excerpts illustrate this:

So I think sometimes eh when you have that interest in you to learn, you learn much than somebody telling you go and do this, go and do this. So if you want to learn I feel you should have that motivation (.) that I want to learn such, such a procedure then you will learn and never forget but sometimes we just learn and you forget just because you didn't have that inner feeling. (St-10-F-4)

So we learn from our own experience. Those who have a heart of learning they will learn but those who need someone to be there it's quite difficult but still more we learn. (St-21-F-3)

Despite the existing challenges and problems within the CLE in Malawi, students' narratives reflect that they learn because of their intrinsic motivation. It is this inner quality that prompts some of the students to work hard despite the adverse circumstances that surround the learning in the clinical setting. The statement, 'those who have a heart to learn, they will learn' was commonly expressed by the students and this actually refers to self-determination and one of the students described it this way:

I can say self-determination how eager you are in the clinical allocation facilitates learning during the clinical experience. (St-14-F-4)

Baillie (1993) identified that students' approach to the placement more specifically, their interest, initiative and attitude are vital in influencing clinical learning. Wilkinson et al (1998) reveal that interest and the perception of relevance determine whether students will participate actively in their learning or not. Student motivation

is not only necessary to enable students to learn but it also helps them to elicit support from clinical staff. If students appear demotivated some clinical personnel do not commit themselves to teach them but they get involved to teach once students demonstrate willingness to learn. One of the students gave the following account of her experience:

There were times I would find myself in a setting but when I just stand doing nothing, everybody would just be looking at me but when I tried to ask questions, to assist here and there I found everybody motivated to teach me something. So I have learnt to say individual motivation to learn matters in a learning experience. (St-8-F-4)

O'Callaghan and Slevin (2003) also reflect the importance of students' interest and motivation to learn in a study which investigated the lived experiences of registered nurses facilitating supernumerary nursing students. O'Callaghan and Slevin (2003:126) reflect the following excerpt from one of the nurses who participated in their study which reveals how clinical nurses feel when they are dealing with students who seem not motivated to learn and the nurse had this to say: 'if they don't have interest . . . you feel that you are beating your head off a stone wall.' This conveys the frustration of clinical nurses as they deal with students who seem not interested to learn.

The study reveals possible sources of extrinsic motivation for KCN students. Where the lecturer as a clinical supervisor personally knows each individual student in a clinical setting by their names, students become motivated and they become eager to work hard but if they are not known they become demotivated and they can leave the clinical setting at any time knowing that the lecturer will not be aware of their absence from the ward. The lecturer's appreciation of what students do in the clinical setting also significantly motivates them but the study reveals that this is a rare occurrence. Students expressed that even though sometimes they may perform below what is expected of them, they should not just be castigated as if they are not doing anything. There should be room for appreciation and if there is need for correction it should be done in a constructive manner and the following excerpts portray these issues:



But when you have a supervisor you know this supervisor, when I am not there she will notice (.) it's even motivating to know that you are known by the supervisor because of course maybe the supervisors may take it for granted but when you are a student then you hear a supervisor calling you your name it's something like a motivation (.) then you have that eagerness even to work hard (St-10-F-4)

Some lecturers just feel like you are doing nothing then you also you also become demotivated you feel that whatever I do they don't appreciate. Like maybe you are doing something when they come they say there is nothing you are doing here you are a senior student (.) and you are doing like you are in first year. I think they should appreciate what you are doing and then explain to you that of course you are doing this but you should do it this way (.) they will motivate you (.) not just demotivating you by telling you that you are not doing anything.(St-24-F-4)

Koh (2002) identified in a study that motivation is the second most significant benefit which occurs as a consequence of practice based teaching by link lecturers. Students are also motivated by clinical nurses who exhibit good attributes. Generally, the nursing image in Malawi seems to be poor such that clinical nurses who possess good virtues motivate students. These are nurses who demonstrate commitment for their work and love for patients. Students identify such nurses as their role models and emulate them so that they can also become good nurses. Students' accounts indicate that clinical nurses rarely appreciate what they do even though they work hard. They commonly point out mistakes and never commend students and the study reveals that appreciation by the nurses is also one of the factors that can motivate students. The following excerpts illustrate these issues:

But when you go there and find a nurse who is polite, (.) who has love for patients when she talks to a patient you could actually see that this person actually has love for the patient. When you see those nurses (.) you are motivated because you see them the way they work, the way they interact with patients (.) then you have that motivation saying maybe if I work like this maybe I will also change the image of nursing. (St-10-F-4)

Most of the times when we are in the ward rarely will nurses appreciate what we do. (.) They only look at the negative side of it; if you do something negative that's when they comment a lot than when you do something positive. (.) So the only time that I was appreciated was when I was at (a mission hospital) I really felt happy yah so it motivated me to do more. (St-9-F-4)

One of the excerpts reflects an interesting perspective where the student reports that the only time nurses appreciated what she did was when she had a placement at a mission hospital. In chapter four<sup>98</sup>, an excerpt from the same student reflects that nurses at mission hospitals are friendly and they work with students without any problem and maybe this explains why the student was appreciated for the first time. I presume the prevailing poor relationships between KCN students and some of the nurses working in government hospitals hinder development of an atmosphere within the clinical settings where people can appreciate each other's work and efforts. Appreciation of what students do in the clinical settings seems to have a substantial impact on student motivation. This is not just motivation to learn but it seems even the motivation to carry on with a load of patient care. Students significantly contribute to patient care and the study reveals that the workload in the wards is quite enormous. One can begin to understand why students feel demotivated when their services are not appreciated simply because of failing to successfully perform some of the nursing procedures. The excerpt below reflects a student being motivated because the patient expressed appreciation of the care she rendered and the student had this to say:

I had this patient who was my case study when I was in year two (.). She had stomach cancer so like it was only palliative. She went to theatre (.) then after she got discharged, (.) then she came to College to see me (.) she even brought a bag of groundnuts for me. It's something that I will never forget that when you do something good people will appreciate (.) and it acts as a motivation for you; you will be encouraged that people appreciate let me even do more. (St-10-F-4)

The study findings also reveal that some doctors motivate students to learn by asking them questions on some of the conditions that patients present with. This motivates the students to read so that they should not be embarrassed in the presence of other people when they fail to answer questions. Some doctors even assign topics for

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<sup>98</sup> See discussion on page 68. A mission hospital is affiliated to a church and such hospitals in Malawi were established by missionaries. The study portrays differences between nurses working in government hospitals and those working in mission hospitals in terms of their conduct towards students.

students to present and this facilitates their learning. To this end, one of the students expressed the following sentiments:

So I would say they have contributed quite a lot to my learning (.) some doctors and some of the clinical officers in the Central hospitals. (.) We could have case presentations (.). That time we thought it was an intimidation but then we realised it was just that the doctor wanted to motivate us so that we should have the spirit of reading. (.) Because when you are a student most of the times eh I don't know what happens but for you to do something you want somebody to push you a bit then you have that motivation. (St-10-F-4)

The excerpt illustrates passive learning among students and this is evidenced by the tendency to be 'pushed.' Although the study reveals that learning was mostly self-initiated, passive learning appears to be a problem as well and reported incidents of absenteeism and abscondment also confirm this. Brown et al (2005) also reflects the tendency among nursing students of wanting to be pushed. My study reveals that absenteeism and abscondment occur sometimes when students are aware that the lecturer will not visit the clinical setting for some time and this is common with placements which are far from the two KCN campuses<sup>99</sup>. This might be one of the areas where students begin to make value judgments about each other and they begin to categorize themselves in terms of who works hard and who is lazy<sup>100</sup>. These findings are congruent with those of Eclock et al (2007) who reveal reliance on staff and passive learning among students who participated in their study.

There is also evidence that students motivate each other and there are several ways in which this takes place. Sometimes senior students motivate and encourage students who have just commenced their nursing studies. Students also motivate each other by sharing what they are learning in the different clinical placements and in this way they challenge and encourage each other to learn what students in other clinical settings have learnt. Students also encourage each other for example, when one is failing to perform a procedure successfully and this helps the student not to despair. Some of the students gave the following accounts:

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<sup>99</sup> See discussion in chapter four under the theme 'Lost Sheep' on page 72 - 73.

<sup>100</sup> See discussion under the theme 'Student attributes' on page 144 - 145

The first time I went to the clinical area I was anxious that (.) I am not going to manage how things are done there but when I went there I was encouraged by the senior students. They used to teach us (.) then eventually I got interested in going to the clinical area. (St-6-M-4)

There were some other procedures that I would do them unsuccessfully. But then they would be there to say ah yes you have failed to do it but I know you can do it because we are able to do it; so you try the next time you will do it. So those words, if my colleagues can do it, I can also do it. So I was motivated to go on up until I did what I wanted to do. So they have been motivators in one way. (St-8-F-4)

When students commence their nursing studies they are enthusiastic and eager to learn. However, the study reveals that in the course of their studies students encounter demotivating factors. One of the demotivating factors has to do with performance below the student's expectation. When students commence their studies in year one, some of them expect that they will be performing well just like they were doing in secondary school. However, this is not always the case and when students observe that they are persistently performing below their expectation they become demotivated. Some of the students expressed the following sentiments:

When I was in year one I was coming like from secondary school and I had all that vigour to work hard. (.)what I thought was that I was supposed to pass with high marks than everybody else. And when I got the first grade I was disappointed that the marks were below what I expected. (.) I used to ask friends because I worked hard, I was always studying (.) Now one of the answers that I got from my male students was that sometimes boys here at KCN sometimes can work hard but their work cannot get appreciated (.) when I went in second year, I never got good marks, so I related this to say ah I think my friends were right (laughter) I can't pass and I was demotivated. St-5-M-4)

You think you were doing best in secondary school when you go to College you will also be doing best. Unfortunately you come here you just have everything it's just up at your hand and this lecturer is telling you do this and this lecturer is telling you do this. So it was just too much for me, I couldn't just capture everything. That's why I was let down to say maybe this is not what I am supposed to be doing. (St-20-F-3)

One of the excerpts also reflects that male students at KCN do not perform well and Simukonda and Rappsilber (1989) also revealed similar findings. The male students who participated in their study perceived the subjects they took to be too advanced for what they do in nursing. In common with existing literature (Okraïneć 1994;

Anthony 2006), the study portrays that male students at KCN find nursing to be academically challenging. Anthony (2006:45) reflects some important questions on this issue which are worth considering and she wrote:

Is it that men are less prepared to succeed in our nursing programmes or is it that we don't effectively accommodate their learning styles and needs?

Whatever might be the cause for the poor performance among male students, they feel that no matter how hard they work; their effort cannot be appreciated by the lecturers. This demonstrates gender bias in assessing male students and these findings lend support to the assertion by Anthony (2004) that gender bias does occur. However, there is need for further investigation to determine if this is indeed a problem at KCN. The study also reveals that a turning point is possible for students who are demotivated due to poor performance and the following excerpt<sup>101</sup> illustrates this:

I specifically remember when I was in third year, because in first year, second year, my performance wasn't all that good and I wasn't motivated to work hard even in class or even in the clinical setting (.). When I was in third year, (.). I was in paediatric department and there it was my first time to care for children (.). Now what I saw was that working in a paediatric department is different from working in adult wards because I felt personally by then that children are so delicate in terms of how they respond to illness; you can easily lose them if you don't manage them quickly. Now what I thought was, in my management I was always making sure I was doing everything on time (.). And after two weeks of working in the paediatric department my lecturer came to supervise me and this white doctor, (.) communicated to my lecturer she said this student is hard working and from there my lecturer told the doctor that if people could really appreciate the remark, what if it was done in writing and this doctor (.) wrote to the College; at the end of everything I was given an award (.). And to me that was a motivation; that was the first time at KCN to get an award and to receive a letter of commendation and that started motivating me and I started working hard and no wonder the following semester I passed with more marks (laughter) (.) So I understood in third year that (.) It's all about hard working, but it only calls for a turning point where you have to be motivated the way I was motivated in third year and that was a turning point for me. (St-5-M-4)

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<sup>101</sup> The excerpt raises other issues such as race but this will not be discussed further. The aim is to reveal what motivated the student.

The study findings also reveal that impersonal approaches<sup>102</sup> to clinical supervision which are employed by some of the lecturers also demotivate students. Students commonly expressed that some lecturers utilise 'policing approaches' while others shout at students in the presence of patients and their relatives which is embarrassing and demotivates them. The 'policing approach' involves the lecturer asking the student some questions in the middle of a procedure in an interrogative way. One of the students expressed the following sentiments:

The clinical supervisor came in, in the middle of the procedure and instead of you having to finish the procedure first and then taking you somewhere else (.). Right away there the clinical supervisor asks you did you explain the procedure to the client. (.). So this client definitely knows this is a learner (.). And all these guardians<sup>103</sup> are looking at you; (.) Some would even (.) say ah they are just students; they don't know anything, I would prefer qualified nurses (.) so it's so demotivating and soon after that you can no longer work and learn for the rest of the day because you keep thinking of that embarrassment. (St-20-F-3)

KCN Students perceive that the clinical assessments which are normally conducted at the end of the placement are biased<sup>104</sup> and sometimes they do not portray a true picture of their performance. As already discussed, this largely occurs because both lecturers and ward sisters who conduct these assessments are not aware of students' performance because they do not work closely with them. This explains how bias is introduced into the process of assessment. Students' accounts reflect amazement at how the clinical grade is arrived at and most of the students expressed dissatisfaction with the grades. What is particularly demotivating is the fact that those students who are not hard working, who are even absent sometimes are the ones who obtain high grades. This is also true for case studies which students have to do during the clinical placement, which also contribute towards the final grade. The study reveals that those students who actually identify a patient and care for the patient get low marks and the student who fakes up a patient and all the care gets a higher grade. The following excerpt reflects these issues:

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<sup>102</sup> See discussion in chapter five under the theme 'Student support: encounters with lecturers' on pages 119 - 120

<sup>103</sup> Guardians are either the patient's spouse or relatives who are normally in the ward with the patient.

<sup>104</sup> See discussion in chapter four under the theme 'Biased assessments' on page 74

What I have observed is that most of the people who are hard working in the clinical area are the ones that get a lower mark. And those people that maybe you are in the clinical area they don't even come to the hospital regularly but when it comes to an assessment, you find ah they are the ones that have gotten a higher mark. So sometimes it's kind of demotivating ah because you say ah anyway even if I work hard. It seems like that grade which you had in year one is the one, it just stays the same (laughter) (.) so it's kind of demotivating (St-10-F-4)

Other demotivating factors include negative remarks<sup>105</sup> which male students encounter from friends and sometimes even nurses for their choice of nursing as a career. Such comments demotivate male students and one student expressed following sentiments:

I've had several circumstances where I was demotivated. (.) As a male student nurse, people have had a mentality that a man could not become a nurse and you could hear remarks of maybe friends who are doing different programmes and you would feel demoralised (.) And you can't even work hard. (.) Sometimes you even hear it from the nurses themselves, the senior nurses, oh why did you choose nursing you as a man? And that simple question gives you a lot of things to think about (.) And that also makes you not to work hard in school or in the clinical setting. (St-5-M-4)

It is now over decade since nursing education in Malawi incorporated male students and yet as the study illustrates, it appears that it is still not socially acceptable for men to join the nursing profession. This could be attributed to the gender<sup>106</sup> role orientation that nursing is predominantly a profession for females. These findings are consistent with previous research (Simukonda and Rappsilber 1989; Streubert 1994; Muldoon and Reilly 2003; O'Lynn 2004; Wang et al 2011)

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<sup>105</sup> The discouraging remarks reflect a common gender issue in nursing education see discussion in Chapter 8 on pages 180 – 181.

<sup>106</sup> The gender issues are further discussed in chapter eight under the theme 'Conceptualisation of care' see discussion on pages 180-181

## **6.2. Peer support and shared learning**

Students contribute significantly to each other's learning and the study reveals that this takes place considerably through peer support and shared learning. Students mostly support each other than lecturers or clinical nurses being there to supervise them. They know each other's strengths; they know who is good at a particular procedure and thus they use each other as a resource to learn. Roberts confirms that there is an emerging body of literature which asserts that students can learn from each other's experience besides their own primary experience which is known as vicarious learning. This is consistent with peer learning which Topping (2005) defines as 'the acquisition of knowledge and skill through active helping and supporting among status equals or matched companions.' According to Topping this involves people from similar social groupings who are not professional teachers for example as in this case, student nurses helping each other to learn. The study reveals that learning considerably takes place as students interact with each other. Normally they are allocated in different clinical settings and they tend to discuss what they encounter in various areas where they are allocated and in so doing they assist each other and promote clinical learning. Roberts (2010) reveals from a literature review that vicarious learning takes place during discourse, discussion, and storytelling where students internalise what is said during the discussion and relate these to their own ideas. Vicarious learning takes place as students learn from each other's experience (Roberts 2010). These findings therefore indicate that KCN students view each other as a valuable resource for learning and this is consistent with previous research (Campbell et al 1994; Hart and Rotem 1994; Lee and French 1997; Koh 2002; Peyrovi et al 2005).

In addition, the study reveals peer teaching and this involves senior students teaching junior students and as they do so they also improve their own skills. Boud (2001:4) define peer teaching or peer tutoring as 'a far more formal and instrumental strategy whereby advanced students or those further on in progression, take on a limited instructional role.' However, the peer teaching which takes place among KCN students is not formally arranged and the following excerpts illustrate these issues:



Most of the times we assist each other, (.) rather than the nurse being there to supervise you. So as students, we are like supervising each other. (St-2-F-4)

And also the help we get from students from senior classes because when we have students from senior classes in that allocation they teach junior students. So the senior students really took a bigger role in helping us to have a good clinical experience. (St-14-F-4)

This shows that experienced students also provide support to novice students and this also has resonance with previous research (Lee and French 1997; Aston and Molassiotis 2003). Sometimes students also learn from each other through presentations which are organised by lecturers and these help students to understand some of the clinical issues they encounter. The presentations take place either at the clinical setting or at the College. However, one of the students indicated the advantage of doing the presentations at the clinical setting as opposed to a classroom at the College and he had this to say:

But when we are having our experience and discussions with the lecturer right at the ward, when there are some questions about how the patient looks like, the presentation itself, we were even leaving the discussion or say after the discussion we had to go to the client, visit her, and see her file including the way she is presenting therefore from that we had to learn a lot of things (St-30-F-3)

Koh (2002) also reported similar findings in that the students in her study indicated that to promote integration of theory to practice, theory should be linked to practice and taught in the practice area as clinical experiences are still fresh and the application of theory to practice is immediate.

The study reveals that shared learning is possible if students have good relationships with each other and they can support each other effectively and poor student relationships hinder its occurrence. Attributes of some of the students are also a hindrance to shared learning. For example, some students display some selfish tendencies and never want to share information. The following excerpts illustrate these issues:

Sometimes you may be allocated to a clinical allocation within the ward with other students but it could also depend on what's the relationship between you and them. And if you don't go on well along with your fellow students,

(.) you may be in a situation where there are so many students but because you have differences you may find yourself you are alone. (St-5-M-4)

There are also some they would really prevent you from doing a certain procedure in the sense that you would say are you in MVA<sup>107</sup> room? (.) Please let me know I would also want to learn. So she is there, for some reasons she doesn't want you to know; whether she forgot, whether she just didn't want you to be there, I don't know (.) but I don't think she would just forget. (.) They are very important to facilitate learning but some of them will hide information because (.) They don't want two, three people to be on the dean's list; they just want themselves to be on the dean's list. (St-20-F-3)

The study also reveals that sometimes male students lack support from fellow students because there is a tendency that female students want to support fellow female students and male students want to support fellow male students and in cases where the male to female ratio is so disproportionate, male students end up lacking support because female students are normally in the majority.

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<sup>107</sup> An MVA room is a room in a gynaecological ward where manual vacuum aspirations are conducted. This is a procedure which is done after an abortion to ensure that all the retained products are expelled.

### 6.3. Student attributes

It is evident from the study that students can be grouped into two main categories; some work hard while others seem to be lazy. Students therefore influence each other positively or negatively depending on the dominating attribute of the students with whom one is allocated with. When a student is allocated with a group of students with a propensity to work hard, then the student also develops a hardworking spirit. Students who are lazy can also negatively influence hard working students sometimes and the following excerpt confirms this:

When you are allocated with those people who are hard-working, you are also forced to work hard just because you want to be in the group (.). But when you are allocated with people the majority of them who are lazy, you see that even when you want to do something they talk. Why are you doing that? You want people like the nurses to know that we are not doing this to shout at us, you should also stop doing that. (.) Sometimes you don't just because they are your fellow students (.) everywhere you make companionships and you always try to be in the group (.). So you find yourself being trapped and then instead of doing the right thing you always say my friends are doing this why should I do this? So sometimes it's not good but we are just doing those things just because of the kind of students we are allocated with. (St-15-F-4)

One of the excerpts above reflects that students who succumb to negative influence do so in a bid to conform and comply with group norms so that they should still be seen to belong to the group. This supports the assertion by Baumeister and Tice (1990) that in order to avoid social exclusion by others, people conform, obey, comply, change their attitude, work harder and generally attempt to present themselves in a favourable light. The negative behaviour which occurs as a consequence of conforming to group norms is consistent with Baumeister and Leary (1995) who reflect behavioural consequences of such conducts and some of these include unquestioning agreement or engaging in negative behaviours sanctioned by group members. It is human nature to desire to belong and Baumeister and Leary (1995) claim that the need to belong is a fundamental human motivation. However, not all students conform and comply with negative influence from other students and this becomes a source of contention among students. One of the students described it this way:

You would see in most cases that students work hard. Maybe at times someone will say oh no you don't have to work hard (.) it's like you want to achieve something and you are always fighting with something. And you see that they are not there to support you (St-5-M-4)

The study reveals attributes of some students which have been crucial in promoting shared learning. Shared learning occurs among students who are eager to learn and those that have an enquiring mind. Such students assume an attitude of being 'one's brother's keeper' such that they ask their peers what they have achieved and what they have not been able to achieve. They will even inform their peers of procedures which are available in their wards but may not be available in other wards thus informing each other of available learning opportunities. Students with such attributes encourage and motivate other students to learn and to this end some of the students expressed the following sentiments:

Ok, these students were students who were eager to learn so through their eagerness to learn, they also contributed to my learning. So they were students in the first place who were there asking me what have you achieved and what have you not achieved and then they would finally say in our ward there is this, this, you can come and do the procedure; so they were there to assist. (St-8F-4)

There are such students who are very hard working that when we go to the ward, they are eager to learn. They will ask wherever possible (.) even a fellow student, how do we do this? (.) so those students have encouraged me because I say if this one is able to do this why not me then I will ask as well, I wouldn't want to be sitting still when there is a plan requiring interventions, and I wouldn't want to come out of a clinical allocation without learning something (.). So from those students who do better, who are most of the times active when they are in clinical placement I have learnt a lot, I have been encouraged and I have adopted that heart of hardworking from them yah. (St-23-F-3)

#### **6.4. Conclusion**

This chapter reflects student related factors which promote or hinder clinical learning. The Student's intrinsic motivation appears to be the key determining factor of whether clinical learning will take place or not. However, extrinsic motivation is also essential as it helps to sustain the student's intrinsic motivation. The study reveals that some lecturers, clinical staff and even fellow students play a substantial

role in student motivation while performance below the students' expectation, impersonal approaches to clinical supervision which are employed by some lecturers, and biased clinical assessments demotivate students. The study reveals that students significantly contribute to each other's learning and there is evidence of both peer learning and peer teaching. The study also portrays the impact of students' attributes on clinical learning. KCN students can be categorised into two main groups namely, hard working or lazy students and the study illustrates that students influence each other positively or negatively depending on the dominant attribute among them. Professional socialisation of student nurses largely takes place through their clinical practice experience and in the chapter that follows I present findings that reflect the nature of students' clinical experience.

## CHAPTER 7: THE NATURE OF THE CLINICAL EXPERIENCE

*Student nurses are to all intents and purpose supposed to be 'learners' that is they are only in practice to learn to be nurses. They are there to gain educational experience. (Holland 2002:1)*

The findings in this chapter have a focus on what students' clinical experience constitutes and some of their narratives portray how they conceptualise care<sup>108</sup>. The study reveals that the major preoccupation of students during the clinical placement is taking care of patients with medical or surgical conditions depending on the ward where they are allocated. The study also illustrates that both patient care and clinical learning are facilitated or hindered depending on the nature of relationships which students develop with individual patients. Students' accounts on encounters with HIV positive patients reflect some pertinent issues which need teasing out considering that Malawi is one of the countries within the Sub-Saharan region which has been severely affected by the HIV pandemic. The findings portray students' attitudes towards caring for patients who are HIV positive and other facets of HIV care. In addition, the study also reflects that students participate in routine activities within the ward which are essentially non-nursing roles and do not contribute to students' learning and one of the students termed this as 'running errands.' The findings in this chapter are presented under the following themes: taking care of patients<sup>109</sup>; encounters with HIV/AIDS<sup>110</sup> and 'running errands.'<sup>111</sup>

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<sup>108</sup> Students' conceptualisation of care are discussed in chapter eight see discussion under the theme 'Conceptualisation of care'

<sup>109</sup> Identified as a theme because the students' accounts indicate that it is their major preoccupation during the clinical placement.

<sup>110</sup> Identified as a theme because students accounts on HIV care reflect some pertinent issues

<sup>111</sup> Identified as a theme though the phrase was mentioned by one student but it eloquently captures the concern expressed by most of the students

### 7.1. Taking care of patients

Students actively participate in caring for patients providing care to meet both physical and psychological needs. Most of the accounts depicted in this chapter are derived from some of the memorable encounters which students had during clinical placements and what makes them memorable experiences is the satisfaction with the outcome of care. Students' accounts reflect a variation of terminologies used to describe the type of care they render to patients but there is a commonality in meaning and the terminologies include 'total care' or 'comprehensive care.' Some of the students gave the following accounts of their experience:

As a student when you are caring for a patient, you get happy like when you are doing the case study and the patient you gave total care to is up again and walking and has been discharged. So when I was in QE I had a patient who was very sick, had a small baby, and had no relatives. So I was there as a nurse taking care of that patient. Ah physically I was there, psychologically I would come assist her with the baby. I would take care of her (.) giving her drugs, feeding her (.) bathing her (.) She was psychologically affected because of the disease condition; she had anxiety because of the child that she had to care for but because she is sick. So she was always anxious. So I was there assisting her (.) to reduce the stress that she had psychologically. (St-2-F-4)

My first memorable encounter, it was when I was in first year, I had a chance of managing a patient with burns. This patient was known to be a satanist (.). So I was the one caring for him because people were afraid that he was a satanist (.). I really gave comprehensive care (.) I was bathing him, I was using Sulfadiazine yah the wounds were dry, even healed fast yah without any complications. And we really established nurse/client relationship (.). We used people from the chapel; they were coming to pray with him. (St-21-f-3)

In the first excerpt the student mentions of 'being there' as a nurse taking care of the patient. This is consistent with Kapborg and Bertero (2003) who indicates that nurse-patient interaction include both 'doing' and 'being.' The second excerpt reflects an account where the student was the only person who was willing to give care to the patient who was labelled as being a satanist<sup>112</sup> because nurses and other students were afraid to take care of him. This is consistent with Rogan and Wyllie (2003) who reflects how students adopt a person perspective and move away from seeing patients

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<sup>112</sup> It is common in Malawi to hear of people who are labelled as satanist and people will avoid them because they are associated with evil. The patient was actually burnt because of some evil he did because of satanism

as stereotypes to being present with them as persons and seeing and responding to their individual needs.

The doing aspect is quite evident in the excerpts above. The students were there providing physical care such as bathing or feeding and other related activities in response to patients' physical needs. Total care or comprehensive care refers to care that incorporates both physical and psychological needs of the patient. However, the study reveals that most of the times psychosocial care is neglected because of nursing shortage and the resultant high nurse-patient ratio which leads to a task centred approach to the delivery of care. Most often the care rendered is not comprehensive focusing only on physical needs arguably, because these are more evident than psychosocial needs. The following voices<sup>113</sup> illustrate this:

When you go to the ward you concentrate on your task you don't look at the patient like comprehensively so it doesn't give a good picture to clinical learning and we don't learn much what concerns nursing because (.) we have a lot to do but we just concentrate on the small part, on the task but we don't do actually do like the psychological care, being with the patient, information giving because most of our learning is based on the task (.) In medical and in surgical wards it becomes difficult because usually there are a lot of patients and then you don't have like much time to do all these other things apart from the task. (St-14-F-4)

From the above excerpts it is clearly reflected that students have an idea of what they are supposed to be doing but time is the main constraint. In one of the excerpts the student indicates that they do not learn much about nursing because they tend to concentrate on the tasks. It appears the only time that students learn much about nursing is when they are caring for a patient whom they have chosen for a case study and this is the only time they can have a holistic view of the patient. Otherwise, for any other patient the focus is on tasks to be accomplished which could include; drug administration, collecting blood specimens, commencing intravenous infusions and blood transfusions and wound dressings. Another student gave an account of her experience in which she took care of a patient who had advanced cancer of the stomach. She chose the patient for a case study and as such her account reflects what

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<sup>113</sup> The issues raised in these excerpts have been discussed further under the theme 'Conceptualisation of care' see discussion on pages 177 - 178



a student does in such caring encounters and she had this to say:

I had this patient who was my case study when I was in year two (.). She had stomach cancer so like it was only palliative. She went to theatre just for bypass (.) because the tumour was so big and metastasis had already taken place. So this patient knew she was going to theatre, she was an elderly woman, she knew she was going to theatre but they did not explain to her exactly what she was going to theatre for because what she told me was that they were going to remove the tumour. So she thought that after the procedure she will be ok. So after hearing that eh I was concerned (.). So I went to that patient with the guardian<sup>114</sup>, I explained to them the condition, what has happened for them to understand the metastasis and all those things. (.) Before she went to theatre the HB<sup>115</sup> was low so she needed a transfusion and I was the one who was dealing with all those things. She went to theatre and when she came back I was the one who looked after her for three days and I was there all the time; I even went there during Saturdays and Sundays just to see how she was. Then after she got discharged (.) she came to College to see me (...) It's something that I will never forget that when you do something good people will appreciate. (St-10-F-4)

The excerpt reflects that the student is the one who had to give information to the patient prior to surgery. The student's initiative is commendable but the account itself reflects issues that touch on the ward setting itself as a learning environment and one is tempted to question the quality of care. If a patient is scheduled for surgery and has no idea what specifically will happen in theatre, then this speaks volumes about the quality of the care and the quality of the students' clinical learning experience. The excerpt confirms that it is the 'little things' that matter in patient care. The excerpt does not reflect much of what the student did in caring for the patient but there is emphasis on being there all the time and that the student even visited the patient on weekends. This is a rare encounter for patients in Malawi no wonder the patient expressed her appreciation by visiting the student weak as she may have been.

The study reflects the importance of nurse-client relationship in caring encounters and it appears students normally develop good relationships with patients. Suikkala

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<sup>114</sup> The guardian is a family member or relative of the patient who normally stays in the ward with the patient

<sup>115</sup> HB stands for haemoglobin

and Leino-Kilpi (2005) identified three types of student-patient relationships which include mechanistic, authoritative and facilitative relationships. Mechanistic relationship occurs where the student's focus is on her own learning needs. In authoritative relationship the focus is on what the student assumes to be the best for the patient. Facilitative relationship is characterised by mutuality, focusing on the common good of both the patient and the student and the students' narratives in this present study reflect such relationships.

The study also illustrates that the patient's attitude towards being cared by a student facilitates or hinders the development of good student-patient relationships. Some patients accept to be taken care of by students where as others openly decline and one of the students gave the following account of his experience:

When I was in second year; I was allocated to (a paying ward)<sup>116</sup> and by then I hadn't developed nursing skills much and my approach to patients wasn't all that professional and I lacked confidence. (.) But I remember there was this other patient who was admitted because of paralysis of the legs and he knew I was a student because I had a name tag and I told him I was a second year student. And in most cases when you tell patients you are a student, some other patients are not interested that you have to take care of them and they are so curious sometimes when you are doing some other procedures that's what sometimes most students fear. (.) When I went to this patient he understood I was a student (.) but also gave me a chance to learn. (.) I had all the confidence because he knew I was a student and I was able to do a lot of nursing care with this particular patient, yah. (St-5-M-4)

The patient's approval of the student's care was perceived by the student as giving him a chance to learn. This concurs with Twinn (1995) who reveals that clients' willingness and commitment to participate in student learning is based on their perception of the student's need to practice clinical skills. The study also reveals that patients' acceptance of care from a student is one of the factors that enable students to render care with confidence. Shen and Spouse (2007) reveals that the willingness of patients and their carers to accept students as care providers is one of the essential factors which affects the learning outcomes of nursing students. Suikkala and Leino-Kilpi (2001) indicate that maintaining a conversation and acceptance of the nursing

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<sup>116</sup> Government hospitals have a paying ward and patients who are admitted to such a ward pay for the services rendered.

care offered by students are important aspects of patient behaviour which promote students' engagement with patients. This present study also reveals that a patient's refusal to be taken care of by students and the curiosity which is demonstrated by some patients when a student is performing a procedure causes fear and lack of confidence in the students and one of the students described it this way:

And in most cases when you tell patients you are a student, some other patients are not interested that you have to take care of them and they are so curious sometimes when you are doing some other procedures that's what sometimes most students fear. So you go to a patient without confidence you are afraid

In common with Lee and French (1997) this study shows that patients can be a source of students' satisfaction with their experience as well as a source of stress. Dunn and Hansford (1997) also reveal similar findings in that the students who participated in their study reported that some patients do not want to be taken care of by students.

The study also reflects other problems which students experience during caring encounters. Sometimes male patients want to extend their interaction with female students beyond the nurse-patient relationship. This significantly affects some of the students to an extent that they begin to detest nursing male patients and some of the students had this to say:

I would say the main problem when caring for male patients is when they want to get too personal with me as a female nurse because let's say when they being discharged they say eh can I have your number? Where can we meet? Something like that ah it's not good (St-26-F-3)

I had a client in (name of ward and hospital) it's a paying ward yah (.) you find that when you are working there you have a nurse to one patient. I was nursing a male client but then the client wanted the relationship to go beyond and the experience I had that time made me to start hating nursing male clients because he would bring in some issues (.) beyond the nurse client relationship. I never I liked it and I stayed for some time hating to nurse a male client saying maybe I may have the same experience um. (St-27-F-3)

Students encounter death of patients as early as year one of their programme and this is one of the challenges which students experience during caring encounters. Death of a patient causes fear in some students and the following voices illustrate this:

In the first place going in the ward the thing I feared most was to see someone dying or see a dead body. (.) So one of the objectives then was also to prepare a dead body. I was so afraid to say what am I going to do? Am I going to take part in preparing the dead body? (.) What is going to happen to me when I go back to College? (St-27-F-3)

Most of the times when it comes to confirming death I was usually afraid yah, (.) So this other day I was on pm shift so the other nurse had gone and the one who was coming for night shift was not in (.) I was in year two at that time and I was left alone (.) and then came this guardian who asked me to go and see her patient. So I knew that they were calling me to go and confirm death; so I was like this is my first time what am I going to do? (St-9-F-4)

Such intense fear was not commonly reported<sup>117</sup> among the study participants most likely because most Malawian nursing students will probably have encountered death in one way or another by the time they join nursing. I presume it is on this basis that most of the students I interviewed did not necessarily indicate fear of a dead person during the early years of their nursing programme. As already discussed<sup>118</sup>, parental counselling is one of the factors which helped one of the students to overcome fears and shock associated with death of a patient. However, the study shows students being affected by death of a patient they felt they were particularly attached<sup>119</sup> to, a patient they loved and in such cases death of a patient is seen as being quite stressful and one of the difficult moments which students experience during clinical placements and the following excerpt attests to this<sup>120</sup>:

I had a patient who was HIV sero positive. She was not yet on antiretroviral drugs because by then the CD4<sup>121</sup> count was ok and there was no need to

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<sup>117</sup> See excerpt St-10-F-4 on page 101 where the student indicates that while they were in year one they would call each other to do last offices reflects that students may not have had as much fear as exhibited by excerpt St-27-F-3 above.

<sup>118</sup> See discussion under the theme 'Stressful experiences' on page 92 and also on page 103 Under the theme Learning to become a nurse

<sup>119</sup> See excerpts St-27-F-3 on page 127 St-8-F-4 on page 153 - 154 reflects being affected by death of a patient she loved and felt like crying

<sup>120</sup> See similar accounts under the theme 'Emotional labour and death and dying' on page 210 -212

<sup>121</sup> CD4 count is a test which measures the number of T helper cells in a patient who is HIV positive. This helps to determine the strength of the patient's immunity and progression to AIDS is diagnosed

commence the treatment. Now upon being told that she was HIV positive she became so depressed that she could not eat (.) When she came in the ward she was vomiting I was in first year of course I could not know the basis for some of her symptoms but I was able to provide basic care. (.) After three days of nursing interventions, the patient started gasping. (.) Our clinical supervisors was within she came with me to the bedside. She said anyway in this case we have to commence oxygen therapy and we only stayed for ten minutes and the patient asked me, 'can I have your hand?' Then she got hold of my hand and that was the first time seeing someone dying and I was shivering (.) I saw the last breath. To me it was the most depressing moment I ever had (.) I was just looking at her physically she was very fat; now she has died it really affected me. (St-7-F-4)

I was caring for the patient and the interaction was so good with the patient and the guardians. I did everything (.) up until when this patient died. And when it happened, the guardian rushed and touched me (.) I was doing other things not expecting, she came and grabbed me, 'Sister, that child has died.' So I was just in her hands, I just stood, I had nothing to say, I just touched her again and we just stood there. (.) So I felt like crying myself because I loved this patient as well, so it was a challenge up until Sister came and took the mother to the office that's when I had to move. (.) I felt like crying as well, but I know I am a nurse (.) it was a difficult moment. (St-8-F-4)

I had a shock when a client died again, that was now in second year. I screamed in the ward coz I never expected that the client would die. I had so many plans that I will do on this client and she will get better. (.) That evening I didn't even sleep in the hostels I went straight home, I had to cry there almost two hours. (.) Then until my father explained to me (.) and even that counselling it's what has helped me to cope up with any scenario when I met a client who has died and I was so much attached (.) I always say oh God it's really something when you have been attached to someone, yah. (St-27-F3)

The excerpts reveal a strong bond that students develop with some of the patients due to good interaction. Students are connected to these patients and detachment due to death arouses emotions<sup>122</sup> in students which they have to suppress but as one of the excerpts reflects the student could not control her emotions but she actually cried. Other studies in literature also reflect students being affected by death of a patient they had a relationship with (Smith 1992; Gray and Smith 2000).

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in adults when the CD4 count is less than 200 cells/mm<sup>3</sup>

<sup>122</sup> Emotions associated with death and dying are further discussed in chapter eight under the theme 'Emotional labour and death and dying' see discussion from pages 210-212

## 7.2. Encounters with HIV positive patients

The study reflects that students also participate in caring for patients with HIV/AIDS and their attitudes of caring for such patients are reflected. This is an area which has been quite a surprise to me and where I had a personal bias. I had thought participants would indicate fear of nursing patients with HIV/AIDS and that this would constitute a major hindrance to their learning; considering that the majority of the patients in Malawi may have AIDS or HIV related diseases as a consequence of the HIV pandemic. However, fear is reported among the students during the early years of their programme due to lack of knowledge. As students' progress in their studies they develop better understanding and are able to protect themselves through infection prevention measures and therefore they develop positive attitudes towards caring for patients who are HIV positive. Some of the students gave the following accounts:

In year one it was much difficult taking of someone who you knew that this patient has AIDS because of the fear that you can have a needle prick injury. (.). And after some years of training that's when I realised that it's ok. It was even interesting to work with those patients because some of them could be open and would tell you all sorts of stories and at least you could help that person. (.) So when you hear those emotions<sup>123</sup> and the problem the person is facing, it's like you get connected to that person and you want to do something more for that person for the wellbeing of that person. (St-10-F-4)

Since first year up to now I have been coming across patients who are HIV positive at first my approach was that of being afraid because I learnt that HIV is not only transmitted through sexual intercourse but through fluids like blood. (.) But as time went by my knowledge began to improve. I realised that if you follow proper aseptic techniques and then even if you care for patients who are HIV positive that doesn't put you at a greater risk of getting HIV infection. (St-29-M-3)

In agreement with previous research (Lohrmann et al 2000; Rondahl et al 2003; Bektaş & Kulakaç 2007) this present study reveals fear of contracting HIV among nursing students. However, in this study, this is a common problem among novice students. Novice students lack knowledge on HIV/AIDS leading to fear of contracting the infection and reluctance in caring for HIV positive patients. This

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<sup>123</sup> Emotions associated with care of HIV patients are further discussed in chapter eight under the theme 'Emotional labour during encounters with HIV/AIDS patients. See discussion on pages 192 - 193

underscores the importance of HIV/AIDS education and indicates that KCN faculty should ensure that by the time year one nursing students commence their clinical placements they should be sufficiently prepared to take care of HIV positive patients through appropriate education. This will help to avoid misconceptions and enable students to provide safe, high quality and compassionate care to patients who are HIV positive (Pickles et al 2009). Earl and Penny (2003) also identified in a study that lack of knowledge causes negative attitudes and unwillingness to care for people who are HIV positive. Consistent with previous research, this present study reveals that negative attitudes or fear of caring for patients who are HIV positive diminishes with appropriate education or adequate knowledge (All & Sullivan 1997; Lohrmann et al 2000; Valois et al 2001; Peate et al 2002; Bektaş & Kulakaç 2007).

The study reveals how needle pricks and other related injuries which directly expose an individual to HIV infection instil fear even among experienced students. It appears that even when the post exposure test is negative a student might develop fear of having the infection with any illness which manifests with symptoms suggestive of HIV infection. The following extract from an interview session with one of the students illustrates this:

**P<sup>124</sup>:** When we were in paediatrics I was putting up blood, I was transfusing a kid but that kid was HIV positive and as I inserted a cannula then that kid pushed me and blood from where I pierced (.) dropped into my eyes and by then I (.) there were some sores in my eyes. But then I felt to say what then? But I didn't go for testing (.) but I went after a week and the results were negative but just three days ago I went again, I had stress to say eh what if I have it, what then will I continue with my education or not? I had a lot of thoughts, I had stress any way but then the results still came negative. (St-23-F-3)

**I<sup>125</sup>:** What made you to go again?

**P:** Because it has been a long time since it happened (.) last two weeks I opened bowels so I was thinking (laughter) maybe it is the infection (laughter) maybe my immunity has gone down (.) but I was afraid. Then but I didn't react to the mother of the child when it happened I knew it happens it wasn't the will of the mother or the child, the child doesn't know what she

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<sup>124</sup> P: speaker identifier for participant

<sup>125</sup> I: speaker identifier for interviewer who happens to be the researcher

does then it became negative I just thanked God. (St-23-F-3)

The study demonstrates that taking care of a relative who is HIV positive also helps to change the students' attitudes towards patients who are HIV positive. Such an experience makes the students to perceive HIV positive patients who are hospitalized as not being different from their own sick relatives. This appears to be one of the major factors which influenced some of the students to develop positive attitudes towards caring for patients with HIV/AIDS and the following voices illustrate this:

When you go home you really see that it's not just in the hospital where people with HIV/AIDS are but even in our homes people are still there. And the way you interact with them (*HIV positive patients*)<sup>126</sup> you see that this is just like somebody who is at home, who is near us that we have to take care of... (St-15-F-4)

So I learnt quite a lot to say; what if these people are my parents? What if these people are my sisters, my brothers how would I want them to be cared? I told myself, I will be in the position of the guardian<sup>127</sup> of that client who is reactive<sup>128</sup>. So I told myself I don't really have to feel like this; I felt well I can do it really yah, yah (.) I felt I really need to help them, I really have to do what I am expected to do; the best I can do. So now I feel any client is the same reactive or not reactive, yah. (St-20-F-3)

Like when I was in first year when you are working with clients who are not cooperative and then you are trying to get a sample and there are moving and all that so (.) you can also prick yourself. I was afraid to say ah it just means this work you are just risking your life. Then when I came to understand it and personally I learnt that I have got a relative who is also HIV positive then I had it in my heart to say I should have the same feeling to say how do I want my relative to be cared? Do I want them to be left without being treated just because they are HIV positive? (St-27-F-3)

These findings concur with previous research which also reveals that previous experience of caring for people living with HIV/AIDS is associated with more positive attitudes towards HIV positive patients (Anderson et al 1997; Peate et al 2002; Bektaş & Kulakaç 2007). Cunningham et al (2006) also revealed that previous experience of looking after ill family members or friends influence students' attitudes and approach to care.

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<sup>126</sup> The words HIV positive patients in hospital have been inserted to promote clarity of the sentence

<sup>127</sup> A guardian is a family member or relative of a patient who is normally in hospital with the patient

<sup>128</sup> Reactive refers to a patient who is HIV positive



The findings also reveal that establishing a therapeutic nurse/patient relationship is very important when caring for patients with HIV/AIDS because the patients are normally anxious and such a relationship instils trust in the patient and allows the patients to open up and express their anxiety so that nurses can assist them to alleviate the negative emotional feelings. Some of the students expressed the following sentiments:

Someone having AIDS is just like everybody else we should not discriminate her she has the right to care (.). I noted that the patient is having ineffective coping: anxiety due to the diagnosis of HIV/AIDS. So the first thing that I was doing is to develop a therapeutic nurse/client relationship. This is important because it instils trust in the client, the client opens up to you (.) you alleviate anxiety. (St-21-F-3)

And then most of the clients who are HIV positive when you are like friendly to them, when you show them love they always have trust in you. They can even start explaining much of their problems to you so that's how I discovered that these clients, the HIV positive clients they need support from us nurses. (St-16-F-3)

I have encountered a lot of patients who have recovered just because you have cared for them with love. (St-23-F-3)

The excerpts reflect that the good nurse patient relationship helps the patient to open up. The relationship conveys to the patient a caring gesture and this has resonance with findings of a study by Smith and Gray (2000) which revealed that when the nurse does not show to the patient that s/he cares, the patient stops talking to the nurse.

### 7.3. Running errands

KCN students do a lot of tasks while on the wards and some of these do not relate to responsibilities of the nurse and are not part of the objectives which students plan to achieve. One of the students referred to involvement with such tasks as 'running errands' and another student referred to them as daily routines and some of the students had this to say:

You are in the wards, the Sister asks you could you collect these blood samples and take them to the lab, could you please go to the kitchen and ask if this patient's food is available. Could you please go maybe to x-ray with this client, can you please go to ultrasound scanning with this client. Well I don't think that would make you a competent nurse because those are not mostly nurses' responsibilities. (St-20-F-3)

You would find a student for example at second year we are supposed to do more advance nursing work. Now for example as second year with your objectives you go into the wards you damp dust, you do bed making, you collect blood samples and the like, you could do that for the whole day that to me is not hard working because you have not first touched your objectives and you are doing very petty issues (.). Some students will just do very petty issues like go to the lab, go to the laundry of course you would physically get tired. (St-28-M-3)

The study reveals that some students get preoccupied with running errands in the ward but this does not contribute to their learning. As one of the excerpts reflect the onus is on the student whether to participate in such ward activities or not and it appears that students who are assertive can easily negotiate for their learning and avoid running errands. Such activities do not promote mastery of neither skills, nor do they make the student competent but they increase the student's workload and hinder attainment of learning objectives and some of the students described it this way:

by the end of the day you find out you've gone to the lab, you've gone to the x-ray, you've gone to the kitchen, you've gone maybe to a certain department just to ask for something else but you did not perform the actual skill that you are required to have by the end of the day, so you are not competent, but you've been running around, you meet lecturers along the way, they say she is a very hard working student. But what has she done? Has she achieved what she is supposed to have done by the end of the day? (St-20-F-3)

And sometimes some nurses will just delegate. (.) Sometimes they are just seated and you are doing something else (.) and it turns out to be a bad learning experience because you are supposed to do what you plan and not being interrupted. (.) but most of the times you find that some of the nurses are just telling you to do some of the things which concerns them but not your learning; like take this patient to the x-ray; take this patient somewhere else while maybe there is a procedure which you need to do which will help you to acquire some skills (St-24-F-3)

Running of errands is a consequence of inappropriate delegation by some of the nurses and students are critical of this tendency. Smith (1992:77) also reflects similar findings in that the students in her study were very critical of ward Sisters and sometimes their staff nurses, who sat in their offices behind closed doors 'sending orders down.'

Hospitals in Malawi have support staff who could do such activities but why do clinical nurses delegate such tasks to students? The study reflects that this occurs due to conflict of interests between the clinical nurses and the students. It appears some clinical nurses do not fully accept the role of students as learners but expect them to do whatever needs to be done in the ward whether appropriate or not. The study reveals that when students are on clinical placements, clinical nurses and even support staff find this as a time for them to relax as well. One of the participants had this to say:

But it becomes a challenge because nurses do not expect you to be doing only your objectives. You are supposed to be doing everything that is supposed to be done in the wards. They feel it's time for them to relax a bit. They are seated in their offices writing schedules, rosters. They will ask you even just to pick a call. They would pick a call and say ok can you go to theatre there is a patient you need to fetch. Ok there are maids<sup>129</sup> out there; there are all these pink nurses<sup>130</sup> they are also there (.). So you would find them they are also having their meetings in the kitchen relaxing instead of helping us. Even this daily linen just to go to the laundry collect linen, or to go to the laundry and at least deliver linen that is supposed to be washed, they are there, they are just resting because we are there (St-20-F-3)

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<sup>129</sup> The word maids in the excerpt refers to health care assistants

<sup>130</sup> The word pink nurses is a derogatory name for auxiliary nurses which derives from the colour of their uniforms

These findings correspond with those of Yazici (2010) who reports of Turkish midwifery students being used as a resource to run errands on the wards, more specifically during night shift. Lee and French (1997) also report that the local Hong Kong student nurses who participated in their study spent much of their time during the clinical placement doing routine and menial tasks which offered little learning opportunities. Gray and Smith (2000) assert that as a consequence of the diminished capacity of clinical settings secondary to increased student enrolments, students may be assigned tasks which are more appropriate for nursing auxiliaries rather than for qualified nurses. The CLE<sup>131</sup> in Malawi has severely deteriorated<sup>132</sup> and it is not surprising that such conflicts of interest exist between the students and some of the qualified nurses. No wonder even the hospital support staff expect students to do their work.

Sometimes students are compelled to go for errands in a bid to seek for some rest. It has already been mentioned that there is a high workload for students during the clinical placements and while this is the case, students are not allowed to seat down. Students therefore collect blood samples, take them to the lab and choose to wait for the results knowing that by so doing they will find time to seat down and one of the students had this to say:

The nurse doesn't expect you to be found in the office seated (.). Well some people have got physical problems, they cannot stand the whole day; they cannot be running around for the whole day, they would want at least to rest (.) you would say ok I would rather get a client to the x-ray you know that when you go to x-ray at least you will find a chair somewhere and you will seat down, when you go the lab at least you are forced to wait for the results of that client because you know I will be seated somewhere. (St-20-F-3)

Students are also likely to run errands fearing that if they refuse there could be an impact on their final grade. The findings reveal that students do whatever the nurses tell them to do and the following excerpt illustrates this:

They would say you are a student you are not supposed to sit down, you are supposed to be doing everything; we are the ones who are going to sign your

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<sup>131</sup> CLE stands for clinical learning environment

<sup>132</sup> See discussion in chapter eight under the theme 'The clinical learning environment in Malawi' on page 166 - 168

competences. So you force yourself even if you are tired. (St-23-F-3)

#### **7.4. Conclusion**

The results in this chapter reflect what the students' clinical experience involves. Students' main preoccupation during the clinical placement includes taking care of adults and children with medical or surgical conditions. Students' accounts reflect emphasis on provision of physical care and the other aspects of care are not as explicit. The study reveals that relationship with patients play a key role in facilitating care provision and clinical learning. Malawi being a country which is severely affected by the HIV pandemic, students' clinical experience includes caring for patients who are HIV sero positive. Fear of contracting HIV infection is reported among novice students but as they gain adequate knowledge on HIV and infection prevention they develop positive attitudes towards caring for such patients. The study also reveals that the students' clinical experience also includes 'running errands' where students find themselves doing some routine activities in the ward which do not necessarily contribute towards their learning. These are tasks or activities which should be done by health care assistants.

This is the last chapter to present results as students narrated them with minimal interpretation and discussion. What follows next is my main discussion chapter in which I reflect my interpretation of the accounts which students gave of their clinical learning experience. Generally, the accounts portray intense emotion work which they engage in due to the emotionally charged situations which confront them during clinical placements. In view of this emotional labour (Hochschild 1983) is the main theme emerging from this study and the discussion chapter exposes the emotion work which students engage in as portrayed by their narrative accounts.

## CHAPTER 8: VOICES OF MALAWIAN UNDERGRADUATE STUDENT NURSES: EXPOSING EMOTION WORK

### 8.1. Chapter overview

In this chapter, the study findings are extended to a discussion to reflect a synthesis of all findings. The study reveals that the clinical learning experience is characterised by enormous challenges due to structural problems prevalent in most clinical settings in Malawi. There is also evidence of relational problems between clinical nurses and KCN students and the student-lecturer relationship is not without problems. All these factors contribute to the emotionally charged situations which confront students during their clinical placements. This illustrates that clinical learning for KCN students is an experience suffused with emotions and emotional labour (Hochschild 1983) is inevitable. In support of Gadamer's (2004)<sup>133</sup> claim that language is 'world disclosing,' students' accounts portray the intense emotion work which characterises their 'lifeworld'. The study findings also lend support to the assertion by Froggatt (1998:332) 'that language is a signifier of hidden meanings about implicit aspects of emotions.' As already discussed in Chapter 3, I draw on Hochschild's (1983) concept of emotional labour and analyse the students' narratives from a perspective of emotions. Whether this is befitting for a hermeneutic phenomenological study is a question one might want to ask and the explanation below provides the justification for this.

Heidegger<sup>134</sup> believed that 'things,' meaning phenomena, present themselves in a 'self-concealing' manner (Moran 2000). This implies that one cannot have a full understanding of the phenomenon being investigated just from the narrative accounts which participants give of their experience. He believed that meaning of the phenomenon can be understood through interpretation of the participants' accounts which manifests the hidden structures (Cerbone 2006). Furthermore, Gadamer<sup>135</sup> asserts that the researcher's foreknowledge helps in the interpretive process hence my knowledge of, and insights into emotional labour enabled me to make manifest the hidden structures of the clinical learning experience for KCN

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<sup>133</sup> See discussion under methodology in chapter three from pages 41

<sup>134</sup> See discussion under methodology in chapter three from pages 39 - 40

<sup>135</sup> See discussion under methodology in chapter three from pages 41-42

students. The students I interviewed may not even know emotional labour as a concept but what resonated from their narrative accounts is the emotion work they engage in. These new insights offer a unique contribution to the understanding of the lived world of nurse learning in Africa.

The study raises issues which touch on both nursing practice and education and the issues on practice seem quite disconcerting and portray some unprofessional conducts. I therefore discuss the identified practice matters prior to educational concerns which the study reveals. I am mindful of the fact that these findings only reflect the students' perspective of nursing practice and nursing education in Malawi. However, the consistence with which these issues featured during the interview sessions compels me to believe that there is some validity in what the students reported as they gave accounts of their clinical learning experience. Consistent with Melia (1982), I would say my responsibility as a researcher is simply to 'tell it as it is.' The aim is not to blame anyone, but rather I would contend that such accounts speak volumes about how some of the nurses feel. I agree with Maben (2009) who claims that most nurses come into the profession motivated to provide compassionate care to patients and I would argue that some factors within their work experience or some external factors cause them to change and appear like they have become hardened. Furthermore, I would argue that the reported unprofessional conducts have a signal function. Freshwater and Stickley (2004) indicate that where nurses are not feeling supported and valued, their practice will suffer. Could this be what the study results are portraying? This is an area requiring further investigation. In view of this, I appraise nursing in Malawi from a perspective of emotions and this is discussed under the theme, 'nursing in Malawi: an emotive subject.'

This discussion reflects issues pertinent to clinical learning in Malawi but my main aim is to expose the emotion work which emanate from the issues. The discussion exposes the students' emotion work during their caring-learning encounters. However, as the study reveals, KCN students encounter emotionally charged situations because of the nature of the CLE in which they find themselves and I feel obliged to discuss the CLE in Malawi before discussing the specific issues on

emotional labour within nurse learning in Malawi. I also analyse the students' conceptualisation of care in view of the knowledge they derive from their clinical learning. This is important because caring is the main preoccupation of nursing and it is important that nursing students should have the right perspective of what it entails. The study findings portray a unique dimension of emotional labour, with emotion regulation and management being evident in students' accounts which relate to provision of care to patients, caring for patients with HIV/AIDS, caring-learning relationships and death and dying and the discussion centres on these themes. Emotional labour is important to this chapter and in the initial part of the discussion I reflect its conceptual framework. This is followed by a discussion on the emotive nature of nursing in Malawi and thereafter the discussion centres on emotional aspects in clinical learning.



## **8.2. Theoretical considerations on emotional labour**

Emotional labour is a concept rooted in symbolic interactionism. Hochschild (1983:7) claims that the labour requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others of being cared for in a convivial safe place.' I conceptualise emotional labour as the internal regulation or management of emotions which takes place when an individual perceives a mismatch between the inner emotions and the expected emotions to be displayed. This is consistent with the assertion by Mann (2005) that emotional dissonance leads to emotional labour. Hochschild asserts that emotional labour is the occupational equivalent of emotion work/management and claims that emotional labour takes place in the workplace while emotion work/management takes place in the home. However, I use these terms interchangeably. Hochschild views the labour as being part of a distinctly patterned yet invisible emotional system. She conceptualises emotional labour as taking place through surface acting and deep acting.

Hochschild's classic work on emotional labour was partly influenced by Goffman's interactional model and similarly I would argue that Goffman's (1959) insight on 'presentation of self' appears to be the main motivation for the emotion work which nursing students seem to engage in. Students seem to be driven by the desire to present themselves as ideal nurses. Goffman (1959:17) claims that when an individual appears before others, sometimes the individual will act in a thoroughly calculating manner, expressing himself in a given way solely in order to give the kind of impression to others that is likely to evoke from them a specific response he is concerned to obtain. Goffman (1959:20) further asserts that each participant is expected to suppress his immediate heartfelt feelings, conveying a view of the situation which he feels the others will be able to find at least temporarily acceptable. These issues are identifiable from the students' accounts. For example, students seem to behave in a calculative manner, suppressing their heartfelt feelings as they interact with clinical nurses. Students reported of avoiding conflicts with ward sisters and befriending them, knowing that the established good relationships will lead to a good clinical grade at the end of the clinical placement. Consistent with Goffman (1961),

in some cases the image that emerges of the student is that of an appeaser. Students also appear to behave in a calculative manner when interacting with HIV/AIDS patients in order to avoid displaying discriminatory attitudes. They mentioned of the need to be 'careful' when interacting with such patients because they tend to be emotional. However, the study also reveals that the sight of an HIV/AIDS patient also makes nursing students to be emotionally affected and Smith (1992) maintains that emotions are the key to connection with patients. Presentation of self also appears to be important in the student-lecturer interactions. Students mentioned that they prefer lecturers who approach them with smiling faces and they employ distancing or detachment strategies to lecturers who are impersonal.

Some authors within nursing have also been instrumental in portraying the application of emotional labour to nursing (James 1989, 1992 Smith 1992,2008 and Bolton 2000,2001), just to mention a few and their work has been crucial in enabling me to interpret the students' accounts from a perspective of emotions. Nurses need to engage in emotional labour in order to maintain a professional demeanour of smiling and compassionate nurses (Bolton 2000; Smith 2008). Furthermore, Smith (1992) mentions of emotionally charged situations which confront nursing students and it is such situations which lead to emotion work. As the study findings indicate, various factors within the students' caring-learning relationships cause them to encounter emotionally charged situations leading to emotional labour. Bolton (2000) identified four distinct types of emotion management which include presentational, philanthropic, prescriptive and pecuniary. The first three forms of emotionality are evident from the students' accounts with the exception of the pecuniary type.

The following sub concepts are identifiable within the concept of emotional labour: feelings rules, emotional dissonance and emotional harmony and engagement and detachment. Feeling rules refer to guidelines for the assessment of fits and misfits between feeling and situation (Hochschild1979:566). Hochschild (1983:18) again defines feeling rules as standards used in emotional conversations to determine what is rightly owed and owing in the currency of feeling. Smith (1992) defines feeling rules as moral stances that guide action. Analysis of the students' accounts indicates

that different feelings rules influence emotional labour during their caring-learning encounters. Some of the students' accounts portray emotional dissonance which requires an individual to suppress instinctive emotions such as disgust or frustration (Mann 2005). Emotional harmony occurs when an individual instinctively identifies with and feels for the patient's suffering and must manage their emotions so as to be detached enough to carry out their role (Mann 2005). This is evident in narratives on students' encounters with HIV/AIDS patients. Other emotional elements which can be identified from the students' accounts are detachment and engagement. Henderson (2001) claims that emotional caring is a choice that individuals make between emotional engagement and detachment while Carmack (1997) emphasise the need to maintain a balance between detachment and engagement for the well-being of care providers. From the students' accounts both detachment and engagement are evident. Novice students detach themselves from HIV/AIDS patients to protect themselves from contracting the infection and senior students tend to identify with the patient's suffering and engage emotionally with them. Detachment is also evident where interactions between clinical staff and students or between lecturers and students arouse negative emotions and students distance themselves to protect their own emotions.

### **8.3. Nursing in Malawi: an emotive subject**

Three main problems contribute to the emotive nature of nursing in Malawi and these include the severe shortage of nurses, the gross lack of material resources and negative attitudes which some of the clinical nurses display towards patients.

Drawing from the accounts which some of the students gave; I reflect how some of these problems contribute to the emotive nature of nursing in Malawi. As the study findings reveal, the gross lack of resources within clinical settings in Malawi sometimes affects students emotionally. This is a common problem in most government hospitals and these are public hospitals serving the greater population in the country. Students' accounts indicate that sometimes the lacking resource is a drug required to treat a patient with a life threatening condition and in some cases death of a patient occurs. The students' narratives portray the emotions and the stress which such a situation can arouse for those providing care and one of the students said, 'It's so stressful and when you stand there with your knowledge, your skills, everything but you can't do anything and it's so stressful.' This illustrates emotionally charged situations which sometimes confront health care workers practising in resource poor settings. The distress which such clinical encounters arouse is quite substantial.

Allcock and Standen (2001) explored students' experiences of caring for patients in pain and the study revealed strong emotions associated with caring for such patients. The authors reveal the helplessness which nursing students experience as in such caring encounters. Similarly, the findings in my study also portray the helplessness which nursing students in Malawi experience when death of a patient occurs due to lack of a lifesaving drug. James (1989) in her classic work within the hospice setting, reveals that emotions such as grief, anger, loss, despair and frustration in family members and relatives are anticipated and considered as appropriate responses in coming to terms with death. Nevertheless, she reports that the expression of such emotions is difficult to watch, and awkward to respond to. Arguably, similar difficulty is experienced by nursing students in Malawi as they watch patients die when they feel that such deaths could have been prevented.

The severe nursing shortage in Malawi also negatively impacts on provision of care. As already discussed, the severe nursing shortage is mainly a consequence of the massive exodus of nurses mostly to the United Kingdom (UK). Malawi lost a substantial number of its nurses leading not only to a 'brain drain' but more importantly, a 'care drain.' Some of the accounts which students who participated in my study gave portray the effects the severe nursing shortage has on patient care. Students mentioned that instead of giving total or holistic care, they try to help each and every patient and that in the end some patients are not attended to. This is consistent with what Hochschild (1995) describes within private life as 'care deficit.' She claims that care deficit is profound in families where working mothers, married and single, lack sufficient help from partners or kin in caring for children. The findings in this study reveal 'care deficit' within health care settings in Malawi.

The study findings also reflect loss of professional pride among some of the nurses and this is evidenced by nurses' lack of commitment and distressingly, tendencies to shout at patients. Some of the nurses seem to have been desensitised to human suffering such that patients are sometimes left unattended. They seem to have lost the passion to care with which they entered the profession. These findings concur with those of Grigulis (2011) who revealed a decline in the quality of care within the health sector in Malawi. Consistent to the findings in this study, Grigulis reveals that some of the evidence of the decline in the quality of care based on the respondents' observations includes nurses having bad attitudes towards patients and nurses not working hard. Pearcey (2010) asserts that when caring stops 'mattering' to nurses a crisis in nursing will truly arise and these findings support this notion and reflect a typical crisis in nursing in Malawi. The study findings reflect students' disillusionment with nursing as it is practiced by some of the nurses. Students reported of nurses shouting at patients over simple matters. The patient's world can be quite frightening and it is the nurses' responsibility to instil hope and reassurance. Fredriksson and Eriksson (2003:139) indicate that nurses enter into 'caring conversations with suffering others.' Consistent with Scheper-Hughes and Lock (1986), I would argue that nurses who shout at patients create a second illness in some patients in addition to their original affliction. Conditions like HIV/AIDS,

which is widespread in Malawi, are associated with intense suffering. How much more appreciated would a smiling and compassionate face be to such patients even though the nurse's inner feelings may be contrary to what is being exhibited? The following excerpt from one of the students who participated in a study by Lemonidou et al (2004:125) is quite instructive and the student had this to say:

[S]he [a nurse] was in and out of the rooms, repeating the same lines, with an air of indifference, not even breaking a smile ... how much a smile would have helped them (the patients) to be more relaxed ....more optimistic ... Being a nurse or doctor, one is compelled, I think, to be warm and humane

Fredriksson and Eriksson (2003:139) conducted a study to explore the ethic of conversation and one of their research questions acts as a helpful guide where interacting with patients is concerned. The research question reads: 'How should the nurse engage in caring conversations with suffering others?' They further point out that the caring conversation is a conversation in which one person through the ethos of 'caritas' makes room for a suffering person to regain his or her self-esteem, and thus make possible a good life (Fredriksson and Eriksson 2003:146).I would contend that within the ethic of caring, there can be no room for communicatively mistreating patients. The findings in this study lend support to the findings by Grigulis (2011) who revealed that a loss of work ethic has been observed in Malawi.

As the study reveals, some nurses in Malawi tend to shout at patients over simple matters<sup>136</sup>. This just confirms that such conducts speak volumes about the nurses' feelings. I agree with Hochschild (1983) who claims that emotion communicates information, it has a signal function and it reflects a buried perspective of the matter. I would contend that shouting at patients reveals a possibility of tension, stress and unmanaged emotions arising from work related stress or personal problems which are projected on patients. Muula and Maseko (2006) confirm that health professionals in Malawi are facing significant challenges which include inequitable and poor remuneration, overwhelming responsibilities with limited resources, lack of a stimulating work environment, inadequate supervision, poor access to continued professionals training, limited career progression, lack of transparent recruitment and

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<sup>136</sup> See excerpts on page in chapter 5, under the theme 'Learning to be a nurse'

discriminatory remuneration. Some of these challenges may be responsible for the unprofessional conduct demonstrated by some of the nurses. Arguably, some of the nurses seem to have been severely affected by burnout debatably, as a consequence their prevailing labour situation. Grigulis (2011) also portrays a possibility of burnout among Malawian nurses and one of the respondents in her study had this to say, 'Is it that nurses in Malawi are so burnt out that they don't care ....? Maslach (1982) reveals that there is no single definition of burnout that is accepted as a standard and she reflects several definitions which all seem appropriate. However, the following definition seem to encompass what is described in this study and it reads: ' Burnout is a process in which a professional's attitudes and behaviour change in negative ways in response to job strain' (Maslach 1982:31). I would argue that shouting at patients occurs exclusively as a consequence of burnout.

Shouting at patients reflects emotional deviance which according to Sakiyama (2009) occurs when care workers cannot exchange 'good' or 'warm' feelings with clients. Hochschild (1983) in her seminal work on flight attendants rightly claims that for flight attendants, smiles are part of their work, a part that requires them to coordinate self and feeling so that the work should seem effortless. She further claims that part of the job is also to disguise fatigue and irritation, for otherwise the labour would show in an unseemly way and the product which in this case is passenger contentment would be damaged. She indicates that such a feat calls for emotional labour. Some similarities can be drawn between flight attendants and nurses in that they are both preoccupied with caring in one way or another and that negative emotions can significantly affect the care they render. Hochschild (1983:11) clearly portrays this similarity by stating that 'most of us have jobs that require handling other people's feelings and our own, and in this case we are all partly flight attendants.'

Vital lessons can be learnt from Hochschild's work on the flight attendants. Shouting at patients reflects the failure to disguise fatigue and irritation and emotional labour can go a long way in helping nurses in Malawi to manage emotions which arise due to their labour situation. McQueen (2004) asserts that the aim of emotion

management is to facilitate the best possible outcome for patients. Emotional labour would also positively impact on the psychosocial environment within the clinical settings in Malawi. To this end, Mitchell and Smith (2003) maintain that emotional labour performance promotes a 'cheerful environment' which makes patients feel safe and comfortable. Mazhindu (2003) revealed in a study that controlling emotions is central to the ability to appear as an 'ideal nurse.' She also claims that acting out of the social construction of an 'ideal nurse' is essential in order to remain calm, sensitive and understanding and that this helps nurses to behave in a socially acceptable manner befitting for professional nurses.

Some of the accounts which students gave reflect total negligence<sup>137</sup> among some of the nurses. Students reported of nurses just sitting in the nurses' station in busy wards, which obviously implies that patients are left unattended. The situation seems to be worse during night shifts because some nurses actually sleep on duty. One of the students had this to say, 'during the night you will find that nurses are just sleeping, they can sleep at 9:00 pm they would wake up at 6:00am.' The study findings also reveal that some of the nurses demonstrate lack of concern. For example, one of the students reported how nurses on a night shift sometimes minimise the flow rate for intravenous infusions so that they should last the whole night, to allow them to have a 'peaceful night shift.' The student mentioned that the nurses would talk about this without any feelings of remorse. This corresponds to what Lifton (1967) and Raphael (1983) cited by Carmack (1997) respectively describe as 'blunting of emotions' and 'psychic numbing.' Hochschild (1983) calls it emotional deadness or emotional numbness and claims that it provides an exit from overwhelming distress whilst the individual remains physically present on the job. Hochschild associates emotional numbness with burnout and claims that the human faculty of feeling still 'belongs' to the worker who suffers burnout, but the worker may grow accustomed to a dimming or numbing of inner signals. I would also contend that the emotional numbness among some of the Malawian nurses is also due to burnout. This could also be due to frequent deaths which nurses encounter in the wards which cause them to become hardened (Smith 1992). Henderson (2001) reveals that emotional engagement is perceived as a requirement for excellence in

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<sup>137</sup> See excerpts on page 113 in chapter 5 under the theme 'Learning to be a nurse'



nursing practice and a situation where nurses appear to have no feelings and no concern for patients must be cause for concern.

Shouting at patients and other behaviours which portray negligence are contrary to what is known about Malawian people. Malawi is often called the 'warm heart of Africa' because of the gentleness and the friendliness of the people (Glasson et al 2006). Malawians are a friendly and smiling people and Tembo (2011) supports this and states, 'it is such wide smiles that Malawians are blessed with that make the country home to everyone.' Would one not expect to find smiling nurses within Malawian Hospitals? The president has named nurses as angels and this is reflected on a billboard (See figure 8.3. below) and it portrays what is expected of Malawian nurses (National organisation of nurses and midwives undated). Angels are a symbol of compassion but it appears such an attribute is not commonly manifested within Malawian hospital settings. One of the students expressed the following sentiments which confirm this assertion and he had this to say, 'It saddens me when I see a health worker, well trained, (.) having a very poor attitude towards the patient. That of course disturbs me because we appear to be angels and we are expected to be one.'

Although the nursing image seems to have been tarnished, the study reveals that there are some nurses in Malawi who are committed and caring. These are nurses who have maintained their passion to care despite the prevailing labour situation and they demonstrate resilience. Such nurses encourage and motivate nursing students and students identify them as role models and as the type of a nurse they would want to be. This reveals presence of 'ideal nurses' in the hospital settings in Malawi and it shows that all hope is not lost. There is a remnant of nurses who have maintained their passion for patients and they are a source of motivation to undergraduate nursing students. Mazhindu (2003:256) questions to what extent the social construction of 'ideal nurse' is affecting new recruits to nursing in the UK? Mazhindu attributes the social construction of an 'ideal nurse' to the vocational origins of nursing and she calls it an 'antique view.' Whether this should be perceived as an antique view is debatable.

**Figure 8.3. A NONM Billboard in Malawi**



Mazhindu reflects that her study findings portray that 'ideal nurses' are individuals who are extremely interpersonally skilled and never allow their true feelings to show in public. She claims that if professional nursing is espousing this 'antique view' it raises difficult questions regarding the provision of higher education in health and social care. I would argue that although in most countries nursing education is offered within higher education, the fact that nurses enter into caring conversations with 'suffering others' ((Fredriksson and Eriksson 2003) remains unchangeable.

The study reveals the extent to which some Malawian nurses engage emotionally<sup>138</sup> with patients. For example, one of the students reported how some nurses call from home to enquire about a patient's condition<sup>139</sup>, which according to the student signifies that the nurse has a connection with a patient. I would also argue that this indicates that some nurses are concerned about the wellbeing of their patients. Heidegger (1962) maintains that to be situated in the world in a state of concern is revealing of being. Benner and Wrubel (1989: 92) rightly claim that there should be concern and they wrote, 'it is crucial that there be concern. Without it, different patients and aspects of their situations would not have salience for the nurse.' The idea of calling from home indicates that some of the nurses in Malawi persistently maintain emotional engagement. Debatably, this connotes over involvement and failure to set limits and boundaries (Carmack 1997). However, this confirms that there are some nurses who engage with patients emotionally which in turn positively impacts on patient care. While some of the nurses seem to have been affected either by the prevailing labour situation or personal problems, the study reveals that some nurses may have personal problems but these do not affect their work performance, they passionately take care of patients. One of the students mentioned that some nurses 'leave problems at the door of their homes'<sup>140</sup> and they do not carry problems with them as they meet with patients in the ward. This reflects observance of professional feeling rules where the nurse knows that she is not expected to manifest a sad countenance to patients due to the problems she is personally experiencing. As Smith (1992) indicates such nurses suppress or subordinate their own feelings to make patients feel cared for irrespective of how they feel. Smith et al (1998:32) also reflect similar findings and the excerpt below reflects sentiments which were expressed by one of the staff nurses who participated in their study and she had this to say:

I very rarely bring any kind of mood to the ward because I believe we are actresses as well (.) the minute I go in the door the smile's on my face and that's the way I've always been and the patients don't know.

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<sup>138</sup> See excerpt St-10-F-4 on page 107, in chapter 5 under the theme 'Learning to become a nurse'

<sup>139</sup> See excerpt St-10-F-4 on page 108 under the theme 'Learning to become a nurse'

<sup>140</sup> See excerpt St-27-F-3 on page 107 in chapter 5, under the theme 'Learning to be a nurse'

I would contend that the display of such a professional demeanour is a consequence of managed emotions. Although the study findings portray loss of professional pride among some of the nurses, I would contend that the presence of nurses who are committed and who engage emotionally with patients conveys a sense of hope for the nursing profession in Malawi. This can be the starting point for the restoration of professional glory and the passion to care among nurses in Malawi. Day (2004) in his classic work on passion centred teaching cites Fried (1995) who claims that passion is discoverable, teachable or reproducible and I would argue that it is also possible to regain the passion to care.

#### **8.4. The Clinical learning environment (CLE) in Malawi**

KCN students gain their clinical practice experience in hospital settings characterised by acute nursing shortage. Nursing shortage is a global problem but what makes these findings so unique is its gravity. Its impact on students' learning is clearly portrayed. It enforces an enormous workload upon students and in addition, deprives them of the much needed support with their clinical learning. The situation is compounded by the reluctance to teach nursing students which is demonstrated by most of the nurses and minimal clinical supervision by KCN faculty. Students therefore reported that their learning is substantively self-initiated and that peers are the only form of support readily available. Peter et al (2004) indicate that many countries are experiencing severe nursing shortage leading to deterioration of nursing working environments and I would also argue that nursing shortage has caused the CLE in Malawi to deteriorate tremendously.

The severe nursing shortage is partly a consequence of the massive exodus of nurses mostly to the United Kingdom (UK). The National Health Service (NHS) of the UK specifically embarked on the recruitment of overseas nurses to lessen its nursing shortage in the early 2000s (Aiken et al 2004; Ross et al 2005; Smith and Mackintosh 2007; Allan 2007), which allowed overseas nurses to come and work in the UK. In addition, some 'push factors' such as poor wages, economic instability, the burdens and risk of AIDS compelled nurses to migrate while as 'pull factors' such as higher wages, better living and working conditions and opportunities for advancement of education and expertise motivated nurses to migrate (Aiken et al 2004). Dovlo (2007) points out that the paradox of the matter is that countries with very low population of nurses were supplying countries with much better ratios of nurse to population. For example, Malawi had a ratio of 0.59 nurses per 1000 population in 2004 while the UK had a ratio of 12.12 per 1000 population as early as 1997 (WHO 2006). Mackintosh et al (2006) views this flow of health care personnel from poor to rich countries as a 'perverse subsidy' and indeed countries like Malawi which lost a substantial number of its nurses are now experiencing the effects.

The Nursing and Midwifery Council (NMC) website reflects reports which depict statistics for overseas registration from 1998 to 2008. I used the statistics from these reports to reflect admissions which occurred from 2000 to 2008 for Malawi and some selected African countries and this is reflected in Table 8.1 below. These registrations reflect the intent to emigrate, although not all nurses who register end up migrating. A total of three hundred and thirty-seven Malawian nurses/midwives were admitted to the NMC register and these statistics reflect that a significant number of Malawian nurses may have migrated to the UK during this period. Gorman (2009) reflects that a total of six hundred and eight Malawian nurse/midwives registered to emigrate within the period 2000 to 2007. This figure is higher than what the statistics from NMC portrays presumably because some of the Malawian nurses/midwives migrated to other countries other than the UK. Alongside nurse migration to the UK, locally within Malawi there has also been an exodus of nurses where a considerable number of nurses left bedside nursing to work in non-governmental organisations which tend to have better remuneration than the public health sector.

**Table 8.1: Overseas Admissions of nurses and midwives (NMC)**

Country	2000/ 01	2001/ 02	2002/ 03	2003/ 04	2004/ 05	2005/ 06	2006/ 07	2007/ 08
South Africa	1086	2114	1368	1689	933	378	39	32
Nigeria	347	432	509	511	466	381	258	154
Zimbabwe	382	473	485	391	311	161	90	49
Ghana	140	195	251	354	272	154	66	38
Zambia	88	183	133	169	162	110	53	51
Mauritius	41	62	59	95	102	71	27	19
Kenya	50	155	152	146	99	41	37	19
Botswana	87	100	39	90	91	44	-	2
Swaziland				81	69	-	-	-
<b>Malawi</b>	<b>45</b>	<b>75</b>	<b>57</b>	<b>64</b>	<b>52</b>	<b>41</b>	<b>-</b>	<b>3</b>
Lesotho				50	43	27	-	-

**Source NMC Reports**

The NMC report for the year commencing 1 April 2007 to 31 March 2008 reflects that only three nurses/midwives from Malawi were admitted to the register (see Table 8.1). This demonstrates a massive reduction in the number of nurses who may have migrated to the UK compared to the years 2001/01 and 2003/04 in which seventy-five and sixty-four nurses were admitted to the register respectively. This confirms that the problem of nurse migration in Malawi has been resolved but certainly its effects will persist for some years. I contend that this massive exodus does not only cause 'care drain,' it also has negative ramifications on the preparation of student nurses for their career as future nurses. Furthermore, I would also contend that this also negatively impacts on performance of clinical nurses because of the excess workload it imposes on them, to an extent that some of the nurses seem hardened.<sup>141</sup>

The study findings also reveal that there is gross lack of supplies in most of the clinical settings in Malawi. This is perceived by the nursing students as a challenge which indicates that the problem affects them emotionally. The impact on students' learning is also clearly portrayed and this is eloquently captured by the theme 'learning in a hard way.' This appears to be a unique problem of the CLE in Malawi and I would attribute this to poverty because Malawi is one of the poorest<sup>142</sup> countries in the world. The study reveals the impact of poverty on both patient care and nursing education. I would argue that besides nursing shortage, poverty has also significantly contributed to the deterioration of the CLE in Malawi. This compromises the quality of the clinical experience and the learning which students derive from it.

Figure 8.1 below gives a better illustration of the situation in most Malawian hospitals because it portrays a hospital balcony being used as a patient room. Students reported that they acquire nursing skills through improvising because they practice in resource poor settings and this hinders them from learning the ideal nursing practice. Shailer (1990) asserts that without both human resources and learning materials, neither the process nor the outcomes of clinical learning can be of

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<sup>141</sup> See discussion under the theme 'Nursing in Malawi: an emotive subject' on pages 217-226.

<sup>142</sup> Malawi has a GDP of \$8.272 (WHO 2009)

the required quality. Students also expressed a concern over the variance between what they learn in class and the practice on the wards and this confirms that the classroom and the clinical setting are 'two different worlds,' as Smith (1992) points out. However, this illustrates a theory practice gap which Jones (1997) cited by Corlett (2000) defines as a discrepancy between what student nurses are taught theoretically and what they experience on the clinical placements.

The study findings portray nursing students being exposed to unprofessional practice through poor role models. Examples of such practice include tendencies to shout at patients, leaving patients unattended and sleeping during a night shift. Greenwood (1993) asserts that students can become desensitized to human need through repeated exposure to poor nursing practice. Kyrkjebø and Hage (2005) cite the American Institute of Medicine (2003) which indicates that a 'hidden curriculum' of observed behaviour, interactions and overall norms and culture of the students' training environment are powerful in shaping their professional values and attitudes. Consequently, the study reflects evidence of negligence among some of the students. It depicts some students sleeping on a night shift just as the clinical nurses did. However as the study reveals that some nurses have got patient care at heart and these positively impact students' clinical learning. Students mentioned of learning some professional values<sup>143</sup> from some of the clinical nurses and this confirms that positive encounters do occur through which students are able to model good practice.

Benner (1984) asserts that expert nurse clinicians possess a body of personal knowledge which is different from academic knowledge and she refers to this knowledge as the 'know-how.' This is knowledge which develops from practice and it is similar to what Schon (1991) termed professional artistry. According to Schon, professional artistry is practical knowledge which is derived intuitively from experience through reflection. The learning transaction between the student and the experienced RNs takes place through what Stockhausen (2006:58) calls *métier* artistry. She defines it as 'a new dimension to reflection-in-action (RIA), displaying the artistry of practice that is demonstrated by registered nurses (RNs) during

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<sup>143</sup> See discussion under the theme 'Learning to be a nurse' on pages 103 - 104



moments of clinical teaching episodes.' Stockhausen asserts that *métier* artistry extends the concept of role modelling and it exposes the students to the deep intrinsic professional artistry of practitioners.

**Figure 8.1: A Teaching hospital in Malawi**



**Source: Malawi Projects Photo stream**

Despite all the problems and challenges prevalent within the CLE in Malawi, anecdotal observations indicate that student attrition is not a problem. KCN students demonstrate resilience and this is evidenced by the statement, 'if one has a heart to learn, one will still learn' which was commonly expressed by some of the students. This reflects psychological resilience which Tugade & Fredrickson (2004:320) define as 'effective coping and adaptation although faced with loss, hardship or adversity.' These findings support the assertion by Lindop (1999) that the ingredient of success in nursing courses is not exclusively related to academic achievement or clinical competence but could be due to determination to carry on despite the stress encountered. Nonetheless, the impact of the prevailing problems and challenges on individual students cannot be completely ruled out.

The study findings suggest that the CLE in Malawi is not conducive to learning because of the prevailing structural and psychosocial problems. On the contrary, students also reported that their learning takes place in Central hospitals which offer them adequate learning opportunities. The clinical settings enable students to encounter the various conditions which they learn in class, which makes them to perceive the CLE as being good despite the existing problems. This reflects satisfaction with the clinical learning experience and it may be on this basis that the students perceive their clinical experience to be a learning experience. Students maintain that the clinical learning experience is important for their professional socialisation. It helps to put what they learn in class in a proper perspective hence promoting their understanding. Furthermore, they allege that their clinical learning is substantial compared to what they learn in class. However, they expressed concerns regarding the quality of the learning experience and a possibility of skills deficit<sup>144</sup> which they attribute to the poor conditions prevalent within their CLE. Spouse (2001) claims that ensuring fitness for award requires that students should have clinical learning experiences of a high standard and most of the clinical settings in Malawi may not offer such experiences hence I would contend that students' fitness for award may be compromised. Cheraghi et al (2008) confirms that student nurses cannot be effectively prepared for their professional role in non-conducive

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<sup>144</sup> See discussion under the theme 'Learning to be a nurse' on page 113

and unsupportive clinical environments.

Whereas most clinical settings seem not to be conducive for students' learning, the study also reveals that private and mission hospitals<sup>145</sup> in Malawi are instrumental in helping students to learn the ideal nursing practice. Students reported that both private and mission hospitals have adequate supplies and that the clinical nurses working in such hospitals are willing to teach students. Figure 8.2 below reflects a picture of a ward in one of the private hospitals in Malawi and when compared with Figure 8.1<sup>146</sup> which reflects a typical situation in most government hospitals in Malawi, I would argue that the observed difference is conversely proportional to the difference in the quality of learning which would take place as students are allocated to these CLEs.

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<sup>145</sup> See discussion under the theme 'Learning in a hard way' on pages 70 -71

<sup>146</sup> See page 173

**Figure 8.2: A ward at a private Hospital in Malawi**



**Source: Adventist Health International website**

The study findings also reveal the nature of the learning which takes place within the CLE in Malawi. What stands out clearly is the fact that KCN does not utilise reflection to facilitate clinical learning. As already mentioned in chapter five, students are encouraged to possess reflective logs but they do not engage in reflective journal writing. They are not given time during clinical placements to reflect on their experience, and there is no provision for guided reflection. Jarvis et al (2003) claim that responses to the constructed experience vary leading to different types of learning which include; non-learning, non-reflective learning and reflective learning and that the learning is non-reflective when it lacks reflection on experience. In view of this, I would argue that clinical learning for KCN students is largely non-reflective. May and Veitch (1998) revealed in a study that formal opportunities within programmes for students to reflect on their placement experiences helps them to process their placement-based learning. These findings therefore reflect lack of structures which can help students to maximise learning from their clinical experience. Mere exposure to an experience does not guarantee that learning has taken place; something must be done to the experience (Kolb 1984; Boud et al 1985; Shields 1995; Fowler 2008). Boud et al (1985) claim that reflection is the key concept that turns experience into learning and Fowler (2008), also asserts that in experiential learning, the learning results from an experience of a certain quality, with meaningful reflection. Denying students formal opportunities to reflect on their clinical experience makes them to miss some potential learning opportunities. In addition, Pierson (1998) asserts that reflection encourages students to become thoughtful individuals capable of critical and innovative thinking and I would contend that the clinical learning experience does not promote development of critical thinking among KCN students.

The study illustrates that KCN lecturers lack a proper structure for clinical supervision and it seems to be conducted substantially on an ad hoc manner and a questioning approach is mostly utilised, guided by questions like, 'what have you done?' This lends support to Lewin (2007) who revealed haphazardness in practical instruction. In addition, the time spent by lecturers in the clinical area is minimal and sometimes they supervise students in more than one ward which even reduces the

contact time making their visits brief. To this end, Clifford (1993) questioned, 'how much could be achieved with very brief clinical visits and what kind of support can be rendered?' It appears reasonable to concur with her. Reiman (1999) maintains that reflection does not occur automatically; innovative teaching strategies are a necessary prerequisite. The time constraint and the ad hoc nature of clinical supervision may not allow KCN lecturers to utilise teaching approaches which can facilitate reflection.

The nature of students' learning is similar to the learning which takes place with an apprentice model of training. Such a model comprises of the acquisition of skills through on-the-job training with theoretical components taught by block or day release (Freshwater and Stickley 2004). Flanagan et al (2000) claims that an apprentice model emphasises 'know how' rather than 'know that' and that the learning is task oriented. This is clearly portrayed in this present study as the findings considerably reveal emphasis on skills learning. Andrews et al (2006) confirm that despite nursing education having moved into institutions of higher learning, the model of learning on placement continues to be an apprenticeship approach.

### **8.5. Conceptualisation of care**

Caring is the main preoccupation of nurses (Milward 1995) and it is essential that nursing students should have a proper conceptualization of what it entails. Students' narratives on patient care mainly focus on management of patients with medical or surgical conditions and the psychomotor skills required in providing patient care. Freeman (1993) indicates that the perspectives which novices develop towards a profession can be identified through the language they use. From the students' accounts one can see that their view of nursing is built around biomedical knowledge and technical nursing skills and some previous research also reflect similar findings (Smith 1992; Lee and French 1997; Orland-Barak and Wilhelem 2005). Smith (1992) in her study attributes a biomedical view of nursing to a nursing programme designed around modules based on medical specialities and a curriculum dominated by a biomedical model. Students who participated in this study also mentioned of modules based on medical specialties which confirms a biomedical approach to the KCN curriculum for the pre-registration nursing programme. I would contend that the biomedical view of nursing desensitises students to psychosocial needs of patients and hinders person centred care. Kleinman (1988) indicates that medicine's focus is the disordered physiology where remedy is brought about through diagnosis and cure. Dossey (2001) argues that this limits healing within the narrow physiologic sense. Mol (2002) asserts that the body and its diseases are more than one and that apart from being a physical reality, having a disease has a meaning to the patient. Similarly, Good (1994) indicates that to the person who is sick, the body is not simply a physical object but an essential part of self. Antrobus (1997:832) states that nurses as a whole seem to be operating in an illness and disease oriented paradigm to the detriment of ignoring or not recognising the more humanistic aspects of their role in the health gain.

Baines et al (1991:11) define caring as 'the mental, emotional, and physical effort involved in looking after, responding to, and supporting others.' Graham (1983:13) defines caring as 'a concept encompassing a range of human experiences which have to do with feeling concern for, and taking charge, the well-being of others.' These definitions reveal that caring is more than just providing physical care. Illness is defined from a nursing perspective as 'a highly personal state in which the person's

physical, emotional, intellectual, social, developmental or spiritual functioning is thought to be diminished' (Berman et al 2008:305). This implies that when an illness strikes an individual, it is not only the physical being that is affected, but the individual is affected holistically. The definition reflects the holistic approach which nurses should take in providing care and it is important that students' conceptualisation of care should portray this holistic view.

The delivery of nursing care in most Malawian hospitals is predominantly task centred, and this may negatively impact on students' conceptualisation of care. This is a consequence of the severe nursing shortage and the resultant high nurse-patient ratio. It is mentioned in chapter seven under the theme, 'taking care of patients' that nursing students mostly concentrate on accomplishing the available tasks and pay little attention to psychosocial needs of patients. James (1989) indicates that in the presence of pressure of work tasks become pre-eminent and other work such as psychosocial care is carried out as time allows. Likewise, Bone (2002) revealed in a study how technical care takes primacy and appears to be mandated while emotional care is given at the discretion of the nurse due to time constraints. The study findings confirm that the nursing care delivery system does not allow students to have an ideal perspective of caring<sup>147</sup>. They are not oriented to a more people centred approach to care and hence they fail to articulate psychosocial components of care. Their narratives fail to convey the nuances of care from a Malawian perspective. Would a therapeutic touch be culturally acceptable to a Malawian patient? This question remains unanswered.

These findings touch on professional dimensions of caring about and caring for. Cronquist et al (2004:68) state that caring about confers a moral obligation on an individual to do what is morally good in a caring situation. They further assert that caring about implies that there is a genuine concern about the well-being of the patient while caring for is task oriented nursing care that is assigned and controlled by superiors. The authors also point out that these professional dimensions are complimentary to each other but they must be kept in a balance. Some of the

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<sup>147</sup> See excerpt in chapter seven under the theme, 'taking care of patients' on page 154



accounts which students gave portray a genuine concern for patients and it appears sometimes they fail to care about patients due to the high nurse to patient ratio. As a result, there is emphasis on providing care to meet physical needs of the patients. Kapborg and Bertero (2003) indicate that nurse-patient interaction includes both 'doing' and 'being' and the findings in this study clearly reflect the former while the latter is not as explicit. The findings lend support to the view expressed by James (1992) that a major difficulty in recognising the components of care is their invisibility and that of all the care components, physical labour is easily identifiable.

Students' narratives also reflect the importance of establishing therapeutic nurse-patient relationships. This is seen as an integral aspect of the nurse- patient interaction and such a relationship is overly essential when caring for patients with HIV/AIDS, because of the associated anxiety. The students' efforts to alley anxiety associated with diagnosis of HIV are consistent with William (1963:87) who asserts that 'the responsibility of the nurse is to provide a stable environment which alleviates some of the strangeness, anxiety and uncertainty inseparable from illness.' Students' accounts also portray that empathy is an important component of care. However, what caring actions convey concern and empathy within a Malawian context? This question remains unanswered and it reflects a possible research area.

Care is also conceptualised as showing love to patients and this is also seen as a very important component of care, more especially when caring for patients with HIV/AIDS. One of the students had this to say, 'I think if you just show them love and care most of the clients with HIV and AIDS recover.' AIDS is one of the conditions known to have no cure yet, but what the study reveals is that caring with love promotes 'recovery.' Csordas (2002) views healing as transformation of a person or self and not necessarily the elimination of symptoms. Debatably, it is the love within the caring nurse-patient relationship which transforms the patient and creates a milieu for healing to take place. Arman and Rehnsfeldt (2006:5) state that caring derives from the Latin concept which stands for giving altruistic love to fellow human beings. Fitzgerald and van Hooft (2000) revealed in a study that within Western healthcare systems, showing love when caring for patients means going

beyond one's duty and entails self-giving. It is the willingness and commitment of the nurse to want the good of the other before the self, without reciprocity (Fitzgerald and Hooft 2000:491). Self-giving and altruism are evident in students' accounts and it appears that these are also the virtues which characterise caring with love from a Malawian context. Arman and Rehnsfeldt (2006) also point out that love in caring is mostly inaudible and invisible hence it is not explicit from the students' narratives how such care is accomplished. Whatever might be the meaning of love in a caring relationship, Watson (2003) challenges us to a new call to bring back that which resides deep in us, to uncover the latent love in our caring work.

There is evidence of gender stereotyping in the way care is conceptualised in Malawi. It is viewed as a role for females. One of the male students who participated in this study mentioned that people have a mentality that a man cannot become a nurse and that because of such a preconception they sometimes make negative remarks and question why a man should choose nursing as a career. Surprisingly, senior nurses also make such remarks sometimes and this indicates that the problem starts from within the profession itself extending to the society in general. In Malawi inclusion of male students in nursing education commenced in 1985 (Simukonda and Rappsilber 1989) and there has been a steady increase in the number of males joining the profession over the years. Nevertheless, the stereotypical attitudes seem to persist. The presence of males in nursing is questioned because the core duty of nursing is caring and this is perceived in every society as being women's work. This is specifically true for Malawi where the traditional gender roles are still influential and caring is strongly perceived as women's work. Thus, although there has been a steady increase in the number of male nurses, I have observed that most of them do not continue as care providers. I would contend that the gendered expectation about men and women in Malawi causes undue role strain on male nurses compelling them to choose alternative career pathways within nursing. The study findings illustrate possible role strain among male student nurses which is evidenced by the statement 'you can't even pull yourself,' which the male student made as a reaction to the negative remarks. This indicates that such stereotypical attitudes affect male students emotionally. Stott (2004) reveals that role strain is a recurring theme for various

studies that have investigated the problems which male student nurses encounter as a result of participating in a traditional female role. Jary and Jary (1991:538) define role strain as 'when an individual is likely to experience tension in coping with the requirements of incompatible roles.'

Traditionally nursing is known to be predominantly a female profession (Stott 2004). However, literature reveals that history of nursing dates back to the third century, with men playing a key role in its evolution (Gomez 1994). During the Judaeo-Christian era both men and women participated in the provision of care and nursing evolved from religious and military orders (Gomez 1994). Anthony (2006:46) claims that the Nightingale factor, that is, her accomplishments in the Crimean war, her social prominence and political influence, combined with the changing perceptions of gender roles in Victorian England were responsible for the foundation of the myth of the feminine nurse in which it was 'natural' for women to be nurses and 'unnatural' for men. Anthony (2006:46) further claims that the vision of a kindly, caring female evolved into the stereotype of 'nurse' following the advent of organised nursing training and men who are perceived as strong, aggressive and dominant ceased to be seen as having a legitimate role in nursing.

## **8.6. A unique dimension of emotional labour**

Several nursing authors have attempted to describe the concept of emotional labour and Gray and Smith (2000:29) state that emotional labour involves 'feelings of care and support which nurses are constantly called upon to instil in patients.' Emotional labour has to do with the emotions and thoughts which nurses feel inwardly but they cannot express them in practice because they do not convey a caring attitude (Huynh et al 2008). James (1992) claims that emotional labour is quite invisible and undervalued unlike the physical care which is quite visible and can be readily identified. The invisibility of emotional labour is related to the gendered nature of emotional labour where it is perceived to be derived from the 'naturalness' of women's caring role (James 1989). Despite its invisibility, James (1992) contends that the emotional component of care like the physical component is labour in the sense of hard work.

Fineman (1993) maintains that organizations should be regarded as emotional arenas. In view of this, emotion management is viewed as an important part of the labour process for both private and public service organisations (Hochschild 1983; Smith 1988, 1992; James 1989, 1992). As already mentioned, nurses need to engage in emotional labour in order to maintain a professional demeanour of smiling and compassionate nurses (Bolton 2000; Smith 2008). I contend that the findings in this study portray a unique dimension of emotional labour. This is due to the problems and challenges within the CLE in Malawi which include severe nursing shortage and gross lack of supplies. In addition, Malawi is experiencing an increased disease burden due to the HIV/AIDS pandemic. All these factors increase the emotional load on students beyond what is normally expected. Smith and Lorentzon (2005) indicate that in the presence of rising patient acuity and critical nursing shortage, most nurses perform emotional labour because they perceive that their actual feelings are contrary to the caring emotions they should display.

The psychosocial atmosphere in some of the clinical settings is not conducive to students' learning. Some of the qualified nurses display negative attitudes towards KCN students and are not willing to teach them. This deprives students of the

support they need from nurses during their clinical learning encounters. Assessment of students' clinical competence has its own challenges and at the same time, student-lecturer interactions in the clinical area are sometimes characterised by shaming practices (Bond 2009). All these issues affect students emotionally and contribute to the unique dimension of emotional labour which students engage in. The study supports the assertion by Smith (2008) that emotional labour is particularly needed when working in distressing situations and I would argue that some of the problems which KCN students encounter during clinical placements appear to be quite distressing. In such situations, consistent with Smith (1992) KCN students significantly require emotion management for them to sustain the traditional image of smiling nurses.

What feeling rules motivate emotion work among KCN students? It seems the student's desire to be an ideal nurse is the main motivating factor. Some of them commence their nursing studies having identified the nurses they do not want to be like and they are determined to make a difference. I would argue that it is this desire to become good nurses that makes them to engage in emotional labour should they encounter any emotional dissonance. The students' accounts reflect that they offer additional gestures of caring despite the problems and challenges they encounter during clinical placements. For example, in chapter four, under the theme 'we cover shortage,' the students' accounts indicate that there is excess work load which makes them to feel fatigued. However, though this may be the case, students seem to be moved by the suffering of patients and they are compelled to go an extra mile. One of the students expressed this, 'When you see different patients suffering (.) you want to help them.' The findings illustrate emotion management not as a way that feelings should be 'commoditized' within the health gain (Hochschild 1979) but for the sake of patient wellbeing. Consistent with Bolton (2000) students seem to be altruistically motivated to engage in emotion management and offer such gestures as a gift.

Bolton (2000:156) identified four distinct types of emotion management which include 'presentational,' referring to emotion management influenced by general social rules, 'philanthropic,' which is emotion management given as a gift,

'prescriptive,' which refers to emotion management influenced by organisational/professional rules of conduct and 'pecuniary,' which refers to emotion management for commercial gain. Although the students' drive to engage in emotion work seems to be largely philanthropic, other forms of emotionality are also evident with the exception of the pecuniary type of emotion management. Mann (2005) reflects two distinct forms of emotion work which nurses engage in depending on the type of emotional conflict. The first form of emotion management occurs due to 'emotional dissonance' and this requires an individual to suppress instinctive emotions such as disgust or frustration. Mann mentions of disgust towards the patient but I would suppose within the Malawian situation such emotions might also arise due to the labour situation and other problems within the clinical settings. Mann suggests that the second form of emotion management occurs to promote 'emotional harmony' and in such cases the individual instinctively identifies with and feels for the patient's suffering and must manage their emotions so as to be detached enough to carry out their role (Mann 2005:309). This is evident in students' accounts of caring encounters more especially caring for patients who are HIV positive.

### 8.7. Emotional labour during caring encounters

The study reveals that KCN students work tirelessly during clinical placements due to the severe nursing shortage and the situation is compounded by the lack of commitment to care which is portrayed by some of the nurses. Therefore, students significantly contribute to patient care and this is consistent with Smith (1992) who revealed in a study that when the ward sister does not care, students take the whole caring attitude upon themselves. Students forfeit their own learning sometimes giving priority to patient care because patients' needs take precedence over their own learning needs. They reiterated that there is heavy work load within most clinical settings and that they appear not to be learning but working<sup>148</sup>.

Holland (2002) contends that it is very difficult to draw a dividing line between learning and working when learning to be a nurse entails being with qualified nurses who are fulfilling their occupational roles. However, such findings indicate that severe nursing shortage negatively impacts on nursing education. The undergraduate nursing students in Malawi are full time students and although this may not be documented anywhere arguably, they are supernumerary. According to UKCC (1986) supernumerary status implies that students are not counted as part of the hospital staff establishment and therefore they are not included on hospital duty rotas and this is true for KCN students. Mashaba (1994:307) defines supernumerary status as implying that 'the student nurses are over and above the required number of nursing personnel as determined by the staff establishment.' Eclock et al (2007) claim that supernumerary status allows students to be part of the clinical nursing team as self-directed learners who participate in the provision of nursing care to patients in order to meet their own learning needs. They further state that supernumerary status offers students the freedom to focus on their learning needs. This implies that as a learner in the practice setting, the student's learning needs take primacy over patient needs and to this end Holland (2002:1) wrote:

Student nurses are to all intents and purpose supposed to be learners that is, they are only in practice to learn to be nurses. They are to gain educational experience.

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<sup>148</sup> See excerpts on page 67 in chapter 4 under the theme 'we cover shortage.'

As Mashaba (1994) indicates, for supernumerary status to be a reality, the student nurses should be over and above the nursing staff establishment. WHO (2011) reflects that in 2010, the vacancy rate for nurses in Malawi was at 74%. This is significantly high and it implies that in Malawi nursing students cannot be over and above the required number of nursing personnel and this explains the reason why supernumerary status may not be a reality for KCN students.

Due to the severe nursing shortage, presence of students on the wards is perceived by the nurses as a time when they can have some respite and they think it is time for the students to work.<sup>149</sup> To this end, students reported that clinical nurses tend to relax when they are on placement. The statement, 'we cover shortage' was a constant theme which most of the students expressed and this reflects a conflict of interests where clinical nurses seem to have a totally different expectation regarding the presence of students in the clinical setting. Students encounter some unique challenges and engage in emotion work as a result of this. For example, sometimes students are left to take charge of a ward independently<sup>150</sup>. Students reported that during night shifts, some nurses would go to sleep and they would tell the students to handle any problem which might arise and not to disturb them. Some of the comments which the students made in relation to these issues reflect the emotion work they engage in as they take care of patients independently. For example, one of the students mentioned of not knowing what to do, a situation he described as being 'stuck.' This implies that internally the students may have fear but I would argue that they will not manifest the fear outwardly whilst taking charge of the ward and will not show to the patients that they are 'stuck.' Consistent with Smith (1992) I would argue that outwardly they might appear to be managing, having a countenance which portrays that they know what they are doing, they are in control and that it is in this endeavour that mistakes happen. I would contend that such encounters involve intense energy expenditure to transform the negative emotions into a socially acceptable professional demeanour. In common with Froggatt (1998) the emotional expressions are presented in a negative way.

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<sup>149</sup> See excerpts on pages 67- 68 in chapter 4 under the theme 'we cover shortage.'

<sup>150</sup> See excerpts on pages 76 – 77 in chapter 4 under the theme 'Lost sheep'



In some clinical settings clinical nurses provide adequate support to students while as in other settings students lack support. However, it appears lack of support is a major problem and this causes students to work under fear, dreading that they might cause death of patients<sup>151</sup>. It is worth asking what has led to all this? Why do clinical nursing personnel adopt a stance which conveys to students that they are there to 'cover shortage?' I would concur with Melia (1987) who in response to similar findings argued that the attitude of the clinical nurses was a reasonable response to the labour situation which confronted them. Similarly, I would argue that the attitude adopted by the clinical nursing staff in Malawi is equally a reaction to the rampant nursing shortage.

As already mentioned in chapter four under the theme 'Biased clinical assessments,' some of the clinical nurses are responsible for assessment of students' clinical competence. This also imposes its own challenges on the students. Students reported that some of the nurses openly tell them that they are not supposed to sit down, they should do all the work in the ward because they are the ones who will sign, endorsing that they have achieved all the required competences. Statements like, 'you are forced' or 'you force yourself'<sup>152</sup> which the students mentioned in response to such remarks indicate some negative emotions which students may experience because of the excess workload. However, although students seem to be compelled to overwork, their commitment and emotional engagement is also explicit, evidenced by the statement, 'if you think of the betterment of the patient.' This portrays some altruistic attitudes which engender such a degree of student involvement. McAllister and McKinnon (2009) state that caring for others involves a high degree of self-giving and that in this endeavour the self can also suffer. This however reflects emotional labour among students because whilst they suffer inwardly, they may not manifest this to the patients but may attend to them with smiling faces. Henderson (2001) claims that nurses' emotional commitment to patients goes beyond what one may feel personally and that this contributes to the quality of nursing care.

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<sup>151</sup> See excerpt St-7-F-4 on page 129

<sup>152</sup> See excerpts on page 68 in chapter 4 under the theme, 'We cover shortage'

I would argue that the students' language portrays an authentic display of emotions and it seems that students manage their emotions for the wellbeing of patients. Literature reflects some debates on authenticity of emotions displayed by nurses during encounters with patients and Smith and Lorentzon (2005) concur that authenticity is potentially compromised when seeking to convey that all is well, even though this may not be true. I would agree with de Raeve (2002) who argues against questioning the authenticity of emotions displayed by nurses during caring encounters. Hochschild (1983) claims that emotional labour is performed through both surface or deep acting and de Raeve (2002:470) argue that the application of acting to nursing is problematic and she wrote:

I would want to claim that a nurse's impetus towards a deepening of his or her understanding and compassion could have nothing to do with acting, whether 'deep' or otherwise

She contends that nurses respond to the needs of vulnerable, often frightened, and suffering people and that it behoves them not to react harshly to patients. She further argues that the nurses' efforts to manage emotions are influenced by a sense of moral concern and should not be viewed as acting. I would contend that even where things may not appear to be well, the nurse's responsibility is to interact with the patient in such a way as to instil hope for a recovery or assist the patient to a peaceful death. Approaching a dying patient with a smiling and compassionate face should not be regarded as deceitful. This would be consistent with the assertion by Bolton (2001) that nurses are emotional jugglers who are able to match face with situation but not necessarily with feeling. Bolton further asserts that nurses are capable of presenting a 'sincere face' whereby feelings matches face or they may present a 'cynical face' to mask emotions which may hinder the manifestation of an acceptable professional demeanour. This is not easy and I would argue that it is on this basis that James (1992) claims that emotional labour is 'hard work.' This however, reflects the associated personal cost of emotional labour, which arguably, is worth the effort and is rewarding. Mazhindu (2003) asserts that work in health related professions and social care work bring its own rewards in terms of altruistic satisfaction and feelings of happiness for the help rendered and the good outcome achieved. Staden (1998) also asserts that nursing is an emotionally satisfying occupation.

KCN students acquire some of the professional values such as compassion and empathy through role modelling as they interact with nurses during caring encounters. It appears the acquisition of such values requires emotional management and the students accounts on these issues are reflected in chapter five under the theme, 'Learning to become a nurse.' One of the students reflects how she learnt to listen and to attend to patients' relatives. Due the severe nursing shortage in Malawi, patient's relatives are normally present in the wards and they are the ones who sometimes alert the nurses of any problems arising. Depending on the nature of their relative's illness, sometimes they are equally apprehensive and may seem to be calling on the nurses 'unnecessarily.' This is an issue which causes some of the nurses to shout at patients and their relatives but the student learnt a nursing virtue out of it. The statement, 'you can't actually find a rationale how that helped the patient,'<sup>153</sup> which the student made concerning her action confirms the assertion that caring has to do with the 'little things' we do (Smith 1992; Pearcey 2010). Another student mentioned that she learnt to get connected<sup>154</sup> to patients regardless of their status and to be empathetic. Larson and Yao (2005) indicate that empathy involves both internal and external emotion management. They define empathy as 'a psychological process that encompasses a collection of affective, cognitive and behavioural mechanisms and outcomes in reaction to observed experiences of another' (Larson and Yao (2005:1102). These findings also support the claim by Smith and Gray (2001) that emotional labour creates an almost invisible bond that the nurse develops with the patient.

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<sup>153</sup> See the excerpt St-10-F-4 on pages 105 - 106

<sup>154</sup> See excerpt St-26-F-3 on page 106

### **8.8. Emotional labour during encounters with HIV/AIDS patients**

Malawi being one of the countries in the Sub-Saharan region which is severely affected by the HIV pandemic, students' clinical encounters includes caring for patients with HIV and AIDS. There is no cure yet for HIV infection and I would contend that fear of contracting HIV infection is an issue which might cause students to labour emotionally. This study reveals fear of contracting the infection among novice students but as they progress with their studies they develop better understanding and are able to protect themselves through universal precautions. This helps the students to develop positive attitudes towards patients who are HIV positive. Students regulate and manage their feelings and begin to perceive patients with HIV/AIDS as any other patient but at the same time they appreciate that they need more support. One of the students had this to say: 'so I told myself I don't really have to feel like this (.) So now I feel any client is the same reactive or not reactive.'

However, incidents such as needle prick injuries might be worrisome to both experienced and novice students. As discussed already, one student gave an account of an incident where she suspected a possible exposure as she was commencing blood transfusion on a child who was HIV positive. She mentioned that she went for post exposure HIV test and the results came out negative. However, she revealed that she went for a second test a week before I had an interview with her because she developed some fears due to some symptoms which she was having and she suspected she might have HIV infection but the results came out negative again. The needle prick injury itself is an experience characterised by negative emotions. The student mentioned that she 'didn't react'<sup>155</sup> to the mother when the incident happened.' This shows evidence of some negative emotions which the student successfully managed. The study reveals recurrence of feelings of fear with onset of symptoms indicative of lowered immunity, leading to a tendency to go for another test. For example, the student reported that she had diarrhoea which instilled fear in her that she might have contradicted HIV infection. The study also reveals that going for the test is also a daunting exercise.

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<sup>155</sup> See excerpt St-23-F-3 in chapter 7 under the theme, 'Encounters with HIV patients on page 162

There is evidence of both emotional detachment and engagement among the students as they care for patients who are HIV positive. Novice students tend to have fear to nurse HIV/AIDS patients and they detach themselves by avoiding taking care of such patients. Some students ensure that they are not allocated in a room where there is a known HIV patient and some avoid performing invasive procedures such as collecting blood specimens. The study findings illustrate that students tend to detach themselves from HIV positive patients in order to protect themselves. Henderson (2001) also reflects similar findings in that some of the nurses who participated in her study employed detachment driven by the need to protect self. The study indicates that emotional engagement with patients who are HIV positive occurs among experienced students. The circumstances of the patient, more specifically, the psychosocial problems which such patients encounter facilitates the student's emotional engagement and one of the students had this to say, 'So when you hear those emotions and the problem the person is facing, it's like you get connected to that person, you want to do something more.' This can be emotionally demanding and therefore the study findings support the assertion by Smith (1992) that the impact of caring for patients with HIV/AIDS increases the emotional load on nurses.

In Malawi the problem of HIV/AIDS is extensive involving almost every family. One may not be infected but could be affected due to HIV infection of a family member or a relative. The experience of taking care of a relative who is HIV positive contributes significantly to changing the students' attitudes and it is one of the factors which influence the students to engage emotionally with HIV/AIDS patients. The students begin to see similarities between the HIV positive patient in the hospital and their relative who is HIV positive. One of the students expressed the following sentiments, 'when you go home you really see that it's not just in the hospital where people with HIV/AIDS are, but even in our homes people are still there.' Herndl (1998:772) indicates that illness is only important when it strikes close to the home. An experience of caring for an HIV positive relative enables the students to become empathetic and to engage emotionally with other HIV/AIDS patients in hospital. The following comment from one of the students illustrates this and she said, 'I have got a relative who is also positive then I had it in my heart to say (.) how do I want my

relative to be cared? 'Lemonidou et al (2004) reveal that students develop moral awareness by identifying and empathising with the patients' suffering which in turn motivates appropriate caring behaviour and this is consistent with the findings in this study. Watson (2003: 197-198) concludes in her seminal paper that 'when working with others during times of despair, vulnerability and unknowns we become challenged and engage in a more authentic process to cultivate and sustain caring healing practices for self and others ...allowing us to engage once again in compassionate care motivated by love.' The positive attitudes towards HIV/AIDS patients which the study portrays are consistent with the views of Peate et al (2002) who posited that people working in health-care institutions should demonstrate a caring and an understanding attitude towards patients with HIV/AIDS.

The students' accounts indicate that HIV/AIDS patients are quite sensitive and emotional, and for them to effectively provide care to such patients they need to engage in considerable emotion work. They should be able to induce or suppress emotions as the situation demands. They perceive that they need to be careful in the way they approach and interact with HIV positive patients. They need to work on their emotions in order to avoid manifesting discriminatory attitudes but to convey a caring attitude. This is consistent with the assertion by James (1992:500) who posited that emotional labour is about action and reaction, doing and being and that the labourer is expected to respond to another person in a way which is personal to both of them. In this case the students are responding to the patient's emotional state and trying to create an atmosphere where the patient will not feel that he or she is being discriminated against because of an HIV positive sero status. Mann (2005:308) claims that the nurse who performs emotional labour is able to manage the reaction of her patient by both providing reassurance and allowing an outlet for their emotions and thus directly impacting on their psychological and physical well-being and recovery.

AIDS is associated with unprecedented suffering and some of the patients are hospitalised in a state in which they have completely despaired of life. The patient sees death approaching and Robins (2006) calls it the 'near death experience.' The

study reveals how some of the students assist HIV/AIDS patients to overcome their anxieties. Students mentioned that when they establish good relationships, patients open up and begin to disclose their anxieties and this becomes the starting point of a helping relationship. The findings reflect self-giving by the students and Fredriksson and Eriksson (2003) interpret this as the gift of a nurse. They assert that if the patient accepts this gift, an invitation to share the patient's world of suffering is possible. Students mentioned of patients opening up and as they share their suffering students are moved with compassion to take care of them. Pask (2003:170,171) maintains that 'compassion can also be understood as an emotion.... an altruistic virtue that involves concern for the good of the other person, an imaginative awareness of the other's suffering, and a desire to act in order to relieve that suffering.'

Benner and Wrubel (1989) indicate that emotions allow the person to be engaged or involved in the situation. Similarly, Smith (1992) maintains that emotions are the key to connection with patients. Students mentioned of getting connected to patients for the purpose of helping them with their emotional problems. This is consistent with Gray and Smith (2000) who claim that the role of the nurse is to act as an emotional buttress to help patients to get over difficult times. One striking feature which these findings convey is the altruism which is demonstrated by some of the students as they take care of the patients. They demonstrate selflessness and commitment to patient care. Antonaccio (2000:134) reflects Murdoch's moral thought on self. Murdoch was one of the deontologists who believed that 'self is such a dazzling object that if one looks there, one may see nothing else.' Pask (2003) seems to have been motivated by such a moral thought and suggests that learners of nursing need guidance and support in order to feel free to concentrate their attention upon the other, and in so doing, learn how they may make a positive difference to patients. Consistent with Murdoch's moral thought on self, Pask recommends that students need guidance to redirect their psychic vision and energy away from the self. I would argue that this is essential for students to be able to engage emotionally with patients.

### 8.9. Emotional labour in caring-learning relationships

The key individuals in students' clinical learning include the ward sisters and other clinical nurses, the lecturers, the patients<sup>156</sup> and the students themselves. Clinical learning therefore takes place within caring-learning relationships. The study illustrates that the main roles of the ward sister in clinical learning in Malawi includes participating in clinical teaching and clinical assessments. There is no indication that the ward sister plays a fundamental role in determining the clinical learning environment in which students learn, which is contrary to previous research (Fretwell 1980; Ogier 1981; Orton 1981; Smith 1992; Dunn and Hansford 1997; Saarikoski et al 2002). The impact of the ward sister's management style on clinical learning is not reflected. This could be attributed to the severe nursing shortage and busy schedules which deter them from effectively influencing the CLE. This could also be due to the massive exodus<sup>157</sup> of registered nurses to the UK so that the present day ward sisters are likely to be young and inexperienced and may not command the respect which ward sisters had in the 1990s and the years before. I remember when I did my nursing studies; the ward sisters and matrons were so powerful such that at one of the teaching hospitals we were required to stand when a matron was passing. Of course as a student I never liked it because it felt like we were in the military. This may have been passed on from the British nursing system since Malawi was one of the British colonies and Smith (1992) describes the traditional British matron as a 'battle axe.'

The study reveals that assessment of students' clinical competence is problematic and there is evidence of bias<sup>158</sup>. This section of the discussion exposes the emotion work which students engage in due to the way the assessments are conducted. Ward sisters and lecturers are responsible for evaluating students at the end of a clinical placement. However, as the study reveals, none of them work closely with students due to busy schedules, which introduces bias into the assessment process and students tend to wonder where the assigned grade comes from. It is a requirement that at the end of a clinical placement each student should be evaluated. Whether

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<sup>156</sup> Issues on patients' role in students' clinical learning are discussed in chapter 7 under the theme taking care of patients see pages 151 - 152.

<sup>157</sup> See discussion under the theme 'The clinical learning environment in Malawi' on pages 166 - 168

<sup>158</sup> See excerpts on page 80 in chapter 4 under the theme, 'Biased assessments'



lecturers and ward sisters are aware of students' performance or not, they have to evaluate the students and come up with grades. This shows how subjectivity is introduced to the assessment process and students reported that the assessments are significantly influenced by interpersonal relationships<sup>159</sup>. Students reported that if they have a good relationship with the ward sister, they are sure of getting a good clinical grade and where the relationship is poor, a poor grade is guaranteed. This demonstrates that clinical grades are not determined by how well students perform but by the nature of their relationships with ward sisters and other qualified nurses. One student described it this way, 'if you were close to them, if you were bringing food (.) you would be friends even if you were not performing well, they would give you good marks.' Such a practice engenders in the students a tendency to be preoccupied with building and maintaining good relationships with the ward sisters knowing the impact of such relationships on clinical grades. I would contend that such a feat requires emotional labour. Hochschild (1983) claims that emotional labour is required where there is need for face-to-face or voice-to-voice contact or where one's action will produce an emotional state in another person and all these apply to nurse-student interaction. These findings are consistent with the assertion by Sakiyama (2009) who argues that in these contemporary times people engage in emotional labour to receive a 'gift' from human relationship.

Students avoid conflicts with ward sisters or clinical nurses knowing that these might negatively impact on the clinical grade. Consequently, they conform and comply with whatever the ward sister/clinical nurse does or tells them to do regardless of whether it is good practice or not and one of the students said, 'you are just a student, you just have to do whatever the nurses want you to do.' Much as conforming and complying appears to make the students' life easy, I would contend that it involves intense emotion work. One of the students mentioned how he avoids conflicts<sup>160</sup> and works in such a way as to appease the ward sister. He mentioned that sometimes the ward sister would leave him to take charge of the ward independently, and he would not point this out because it is the same sister who at the end of the placement will evaluate him together with the lecturer. The student reported that the Failure to point

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<sup>159</sup> See excerpts on page 83 in chapter 4 under the theme, 'Biased assessments'

<sup>160</sup> See excerpt St-5-M-4 on page 81 in chapter 4 under the theme, 'Biased assessments'

out such unprofessional conduct is a challenge. This means internally the student might have negative emotions but will not express them because one must by all means avoid conflicts with the ward sister for fear of consequences on the final grade. Smith (1992) also reflects similar findings in that emotional activities of the students who participated in her study centred on the regular practical assessments which were conducted during their ward placements. The most striking feature of the students accounts are their attempts to build and maintain relationships such as befriending the nurses and bringing food for them which reflects a subtle kind of trading and negotiation that goes on between the qualified nurses and the students. The tendency to appease ward sisters also confirms the trading and negotiation which goes on between the clinical nurses and the students. Another student expressed this, 'Is it always the student who is supposed to start saying hi (.)you want to get better grades so you are supposed to appease them. So you are forced to say hello.' This is consistent with the assertion by Goffman (1961:139), who in his classic work on encounters wrote:

That a situated activity system provides an arena for conduct and that in this arena the individual constantly twists turns and squirms, even while allowing himself to be carried along by the controlling definition of the situation. The image that emerges of the individual is that of a juggler and synthesizer, an accommodator and appeaser...

In all this students seem to be trading and negotiating for good clinical grades and these findings concur with the view that students are mostly assessment driven (Bourner 2003). Becker et al (1968: 45, 55) posit that 'grades are the currency of the campus... they are the major institutionalised reward available for academic work ....They are a measure of personal worth, both to others and to oneself, just as money does to the larger society.' This explains why students seem to be so much preoccupied with 'making the grade.' In common with Diekelmann (1992) this reflects that emphasis on evaluation results in practices that are problematic for both teachers and students. Similarly, Toohey et al (1996) indicate that the desire for assessments method which allows comparison and ranking of students is one of the factors which cause complications when assessing the practicum. The emotional labour that occurs in this case is influenced by a different set of feeling rules. It is

motivated by the desire to obtain good clinical grades.

The psychosocial atmosphere within some clinical settings is poor. Some nurses exhibit negative attitudes towards KCN students and as already discussed this seems to be associated with the fact that they are pursuing a bachelor's degree, a qualification which most of the practising nurses do not possess. Consequently, some nurses demonstrate unwillingness to teach the students during clinical placements. Nonetheless, students are not entirely innocent; they also have their share in the existing relational problems and one of the students described it this way, 'sometimes you don't just blame the nurses but us students we can turn somebody to become hard who was not like that.' This partly explains the reason for the contention between the students and some of the clinical nurses. I recall the days when I was a student nurse, the psychosocial atmosphere was not as bad as it sounds now, and yet we were pursuing a diploma which many of the practicing nurses did not possess. This just confirms that indeed the students are partly responsible for this. Tveit (2008) cited by Solvoll and Heggen mentions of the concept of the 'new youth' and I think this partly explains the basis for all the contention going on. Tveit indicates that the new youth have the 'what's in it for me' attitude. This is not the case with KCN students but rather I would argue that they are not as tolerant as students would have been two decades ago.

However, these findings reflect some of the problems which occur due to lack of standardization<sup>161</sup> of nursing education in Malawi. There are two main cadres of nurses in Malawi namely, the registered nurse and the enrolled nurse and the latter are presently named nurse technicians. Even among registered nurses, there are those that have gone through a university based education system and others have not. There are post basic programmes for both registered and nurse technicians to upgrade but the fact that some institutions continue to train nurse technicians, it means that Malawi will continue to have the two different cadres of nurses. The study illustrates that lack of standardised education of nurses is the main cause of the

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<sup>161</sup> By standardization of education I refer to having an education system for nurses which will produce one cadre of nurses with one type of award for example, registered nurses with Bachelor's degree.

problems which KCN students encounter in some clinical settings and this leads to serious relational and attitude problems between students and qualified nurses. These findings have resonance with the assertion by Andrews et al (2006) that the inclusion of nursing education into institutions of higher learning has led to tension between university and non-university educated nurses. Spouse (2000) posits that as a consequence of the transfer of nursing education to institutions of higher learning, clinical placements can become places of contention and conflict where students may experience a high level of stress and disillusionment and the findings in this present study attests to this.

In some clinical settings the CLE appears to be quite hostile and oppressive and students are shouted at. This in essence is tantamount to bullying and it leads to abscondment, absenteeism and non-learning. Non-learning occurs because bullying instils a sense of fear in students so that they cannot ask questions. Edwards and O'Connell (2007) indicate that incidents like bullying lead to low morale, diminished enthusiasm and reluctance to work and this also explains why absenteeism and non-learning occurs. Whether shouting at students is acceptable within the Malawian culture is something worth teasing out. I would contend that this occurs because the Malawian culture is quite paternalistic and I doubt if perpetrators of such a conduct see themselves as engaging in bullying. However, students do not like being shouted at and this explains why where this is a common occurrence it leads to abscondment and absenteeism.

Students' accounts also portray the emotion work which they engage in when they are allocated to clinical settings which are oppressive and hostile. In such cases emotional labour occurs in response to poor relationships and one of the students said, 'I had a bad experience (.) I went there not a lot of days (.) The moment you do something, they shout at you!' Notice that the student says 'she went there not a lot of days.' This reflects absenteeism and it illustrates a detached stance or distancing strategies which students employ to protect themselves from unwarranted emotional load. Smith (1992) asserts that persistent exposure to extremely difficult circumstances will cause students to either choose to leave or develop strategies to

protect their emotions. Smith refers to such difficult circumstances within CLEs as the lack of caring factors and I would argue that shouting at students is an example of such factors. Students tend to distance themselves from oppressive environments through either absenteeism<sup>162</sup> or abscondment.<sup>163</sup> One of the students had this to say, 'if the nurses are not friendly, (.) not approachable, you cannot learn much in that ward (.) this contributes to students 'running away' from the ward.' It appears students employ these distancing strategies following student-nurse interactions in the clinical settings which produce negative feelings.

However, students reported that some nurses are willing to teach them and greater ambience is guaranteed in such clinical settings. Students feel motivated and they never want to leave the setting and one of the students described it this way, 'But there were some settings (.) I wouldn't want to leave that setting, (.) because of the friendliness of the people and their eagerness to teach.' This is interesting to note that where the psychosocial atmosphere is poor students distance themselves and where it is congenial, they want to continuously engage with the nurses and they do not want to leave the setting. The receptiveness of clinical nurses towards students, and their willingness to engage in a teaching relationship are the major factors that enhance clinical learning whereas, negative attitudes; poor student-nurse relationships and the unwillingness to teach students are its major deterrents. The study reveals that clinical learning does not occur in CLEs where the psychosocial atmosphere is poor, but where it is congenial and where nurses and students have a collegial relationship. The following extract from one of the students confirms this and she had this to say, 'So you would work with them as your colleagues (.) and you would say at least we are meeting somewhere, so those are nurses that facilitate learning.'

The study reveals that KCN lecturers fail to effectively fulfil their clinical teaching role and to support students during clinical placements due to workload and other commitments. Carlisle et al (1997) revealed pressure of academic work, lack of time, not viewing the clinical role as a priority and lack of up to date clinical skills as some

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<sup>162</sup> A student's temporary non-attendance at a clinical placement which occurs following a difficult experience

<sup>163</sup> Abscondment refers to a tendency among students to leave the clinical placement secretly but temporarily and normally occurs following a difficult experience.

of the barriers to the clinical teaching role. In common with previous research, the study confirms that consistent clinical supervision is in reality difficult to achieve (Koh 2002; Lord 2002; Aston and Molassiotis 2003). However, Forrest et al (1996) revealed that nurse teachers have a potential to play an important role in the clinical area despite the role failure and this is consistent with the findings in this study. Students prefer that lecturers should spend more time with them in the clinical setting and should teach them through direct patient care. Arguably, this is an indication that they consider student-lecturer interactions in the clinical setting to be beneficial to their learning. These findings support the assertion by Brown et al (2005) that the presence of lecturer in the clinical environment is significant in that it offers support to students. Conversely, the need expressed by KCN students that lecturers should teach them by direct patient care is contrary to previous research. For example, students who participated in a study by Papp et al (2003) did not consider the teacher to be an important facilitator of their clinical learning. Previous research also indicate that teaching through direct patient care by link lecturers or other designated faculty members is perceived as disruptive, unrealistic and frustrating (Crotty 1993; Elliot 1993; Forrest et al 1996; Corlett et al 2000). This seems to be one of the main differences between nursing education in western countries and nursing education in Malawi. In western countries the trend is towards the mentor being central to the facilitation of clinical learning whereas the lecturer assumes a liaison role.

Why do KCN students prefer to be taught in the clinical area by lecturers is a question which comes to mind and the study findings reflect reasons for this. There is dissatisfaction with the teaching by some of the clinical nurses. For example, one of the students said, 'We learn things from other nurses and most of them don't do procedures rightly as it is written in the books.' Some of the nurses also doubt their own credibility to teach undergraduate nursing students. This may not be surprising considering that the majority of the practising nurses are enrolled or nurse technicians<sup>164</sup> and it appears students interact extensively with this cadre of nurses than with registered nurses. Nonetheless, students do appreciate the support which some of the enrolled nurses render to them and this shows that some of them are

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<sup>164</sup> See statistics in chapter one on page 4

committed to support students' learning and this is commendable. However, the concerns expressed above still stand and this explains why students prefer that lecturers should teach them by direct patient care.

The study supports the assertion by Chapple et al (2004) that inadequate support is offered to student nurses during their clinical experiences due to nurse lecturers and clinical nurses' failure to fulfil their roles. Consequently, much of the learning which takes place during clinical placements is self-initiated and as discussed in chapter six, there is also evidence that students also learn from the experience of peers, which is known as vicarious learning (Roberts 2010). This is consistent with Papp et al (2003) who revealed in their study that students are primarily responsible for getting the most out of their experiences. This also supports the notion that students are masters of their own destiny (Wyatt 1978; Gray and Smith 2000). This however, translates to a situation where there is lack of leadership for students' clinical learning (O'Driscoll et al 2010) and no wonder one of the students mentioned that they feel like 'lost sheep.' I would contend that this is one of the factors which cause students to encounter emotionally charged situations. Carlisle et al (1997) argues that linking theory to practice is a complex task and students should not be left alone to draw links for themselves but should be supported. Similarly, Birchenall (2001) asserts that without facilitation of clinical learning students may not be able to glean anything worthwhile from their experiences.

The study reveals emotion work among students engendered by factors which relate to the student-lecturer interaction in the clinical setting. The minimal clinical supervision militates against the development of effective student-lecturer relationships. In addition, the infrequency and shortness of visits to the clinical area by lecturers hinders students from becoming acquainted with them. This creates a situation where the presence of a lecturer in the clinical setting is perceived by the students as a threat and it induces stress and one of the students had this to say, 'most of the lecturers tend to be friendly (.) while in class, (.) when it comes to the ward it's not what happens. Somebody is very high, somebody is very low.' This illustrates that sometimes hierarchical relationships exist between students and lecturers during

clinical placements. This is contrary to students' expectations of a collegial relationship with both clinical nurses and lecturers.

Some lecturers employ what students term 'Policing approaches' of clinical supervision and others have a tendency to shout at students. The following comment from one of the students illustrates what 'policing' entails and the student had this to say, 'The policing is done in the sense that you are doing the procedure and the supervisor comes in, starts asking you questions.' This is consistent with what Gillespie (2002) calls 'non-connected' student-teacher relationships. Gillespie (2002:572) reveals that 'non-connected' teachers have a tendency to 'grill' students with questions, offer only negative feedback, constantly critique and 'watch them like a hawk' and KCN students expressed similar concerns. Bond (2009) maintains that the professional socialisation of nursing students requires social-relational connection with the instructor if students are to learn professional norms and values. Consistent with this view, my study reveals the need for KCN lecturers to identify with each student by knowing them. When a lecturer calls students by their names, it motivates them. The study illustrates that the student-lecturer relationship should be holistic, meaning that it should focus on both the academic and personal life of the student. This might sound like invading into the student's space but I would argue that there are times when this is necessary. The study reveals that some students encounter personal problems and I would suggest that to identify such students and to effectively help them requires knowing them personally.

Gillespie (2002) reveals that connected student-teacher relationships are characterised by caring, knowing, trust, respect and mutuality. Literature reflects that nurse educators should espouse caring student-teacher relationships because for students to implement caring practices it is required that they experience caring during the course of their studies (Diekelmann 1990; Beck 1991; Hughes 1992; Lopez 2003). Nylund and Lindholm (1999) suggest that the ethical dimension should form part of clinical supervision for students and they propose that supervision should be based on the same premises as caring ethics. Caring faculty behaviours enhance students' confidence and self-esteem while uncaring behaviours make the



students to feel hurt and diminishes their self-esteem and self-worth (Hughes 1992; Nylund and Lindholm 1999).

The 'Policing approach' arouses negative emotions in the students and the following comments confirm this and the student had this to say, 'the clinical supervisor'<sup>165</sup> would come in the sense like policing you, so you are definitely scared! You cannot perform that procedure as it is expected just because you are anxious!' As already mentioned in chapter five, this is one of the factors which make students to 'learn in a hard way.'<sup>166</sup> Students also reported that some lecturers approach them in the clinical area with gloomy faces and one of them described it this way, 'Some lecturers come as if they are already angry with something else (.). They are just coming with an angry face and you just run away.' The tendency to run away from the lecturer is a distancing strategy which students employ when they are handled in an impersonal way. I would contend that a gloomy countenance indicates failure by the lecturers to suppress or induce feelings accordingly and all these issues simply confirm that student-lecturer interactions in the clinical setting can be considerably stressful sometimes and students perceive lecturers to be a major stressor.<sup>167</sup>

The negative emotions induced by the presence of a lecturer in the clinical setting causes students to make mistakes as they perform procedures or causes them fail to answer questions for things they legitimately know. Weiss (2000) cites Caine & Caine (1997) who indicate that an experience of high levels of stress within a learning situation is followed by a psychophysiological response which is characterised by feelings of helplessness or fatigue and this deters an individual from using higher order, more complex thinking and creativity. Weiss (2000) also indicates that brain based research shows that emotions and thought are interconnected and this explains why emotions interfere with rational thinking. Similarly, Smith (1992) indicates that handling students in an impersonal way causes them to temporarily lose both their technical and emotional confidence to care for patients. The policing approach indicates that some lecturers interact with students in

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<sup>165</sup> The word clinical supervisor refers to a lecturer in her role as a clinical teacher

<sup>166</sup> See excerpt St-20-F-3 on pages 126-127 in chapter 5 under the theme 'Student support: encounters with lecturer'

<sup>167</sup> See Excerpts on pages 91-92 in chapter 4 under the theme 'Stressful experiences'

an autocratic way and Griffith and Bakanauskas (1983) assert that such approaches to nursing education produce a sense of powerlessness in the students which negatively impacts on the learning process.

Students reported of shame and humiliation which occurs as a result of lecturers shouting at them or correcting them in an embarrassing manner in the presence of patients. This is consistent with Bond (2009) who supports that shaming practices do occur in nursing education and that they seriously impede effective teaching and learning. Bond reveals that potentially shaming practices in nursing education include: correcting a student in front of patients, staff or peers; ignoring a student; becoming impatient with a student; displaying verbal or non-verbal contempt in response to student's lack of knowledge or skill; or refusing to provide help to a student. Students resent lecturers who embarrass them and they employ distancing strategies to protect their emotions. Sometimes students even develop animosity towards such lecturers and one of the students had this to say. 'I felt very bad when a certain lecturer shouted at me in front of the patient (.) and I don't like the lecturer up to now.' This concurs with Halldorslottir (1990) who revealed in a study that uncaring faculty behaviour make nursing students to feel 'hurt' and 'torn down' and diminishes their self-confidence, self-esteem and personal worth. It is such uncaring behaviours and the ensuing negative emotions which cause students to employ distancing strategies. Bond (2009) cites Kaufman (1985) who reflects that shame has an alienating effect which he calls 'breaking the interpersonal bridge' and this explains why students employ distancing strategies.

The study reveals that lecturers tend to shout at students when a mistake is made in the course of a procedure. It appears this arouses negative emotions in lecturers making them to be emotional and one of the students said, 'I feel lecturers (.) should not be too emotional, when you have done something wrong.' Arguably, this indicates that such tendencies are a consequence of unmanaged feelings and illustrates the need for lecturers to equally engage in emotional labour for them to effectively facilitate clinical learning. Students' accounts indicate preference for lecturers who are calm even when they find a student making a mistake. They prefer

student-lecturer interactions which maintain their self-worth and resent being shouted at or criticised in the presence of patients which embarrasses them and makes the patients to lose trust over them. Midgley (2006) asserts that the clinical field is where students learn to care and it is important that they feel valued and have a feeling of self-worth. Clinical teachers need to be supportive and respectful in their relationship with students which leads to greater motivation and makes learning possible (Day 2004; Bond 2009; Aghamohammadi-Kalkhoran et al 2011). Lecturers should demonstrate interest in students and approach them with smiling and friendly faces. Greeting an individual is something which is often taken for granted but this study reveals that it plays a key role in enabling students to be calm and relaxed. The lecturer who does not greet the student but just begins to 'fire questions' makes the student to be apprehensive. How the student is approached by a lecturer in the clinical setting determines whether the student-lecturer interaction will be fruitful or not. Smiling and greeting the student makes a substantial difference and this illustrates that even in the student-lecturer relationship it is the 'little things' that matter. One of the students said, 'they should also be smiling at us, and they should be youth friendly.' It is not always easy to smile, more especially when the inward feelings are contrary. This reflects the role of emotional labour in the promotion of clinical learning and Day (2004) claims that good teachers invest large amounts of their substantive emotional selves in pursuing their work with students and I would contend that it is the emotional commitment of lecturers which is being called for.

### 8.10. Emotional labour and death and dying

Nursing students in Malawi encounter death of patients quite early in their programme and the study reveals that this is an area which sometimes causes them to become emotionally affected. One of the students mentioned that she was caring for a patient and had established a good nurse-patient relationship. She gave the following account regarding the patient's death and she said, 'When this patient died, I felt like crying as well, but I know I am a nurse.' Similarly, another student mentioned of the emotional distress she experienced due to death of a patient. This was a patient who was diagnosed as being HIV positive but her CD4<sup>168</sup> count was still normal and therefore did not require antiretroviral therapy (ART). However, the patient became severely depressed due to the HIV diagnosis and died. The student reported that it was her first time to see someone dying and she saw the last breath. She mentioned that this was the most depressing moment and she had this to say, 'I was just looking at her, physically she was very fat, now she has died, it really affected me.'

Another student mentioned of experiencing shock due to death of a patient and she reported that she 'screamed' in the ward because she never expected that the client would die. She could not sleep in the hostel but went home to her parents and cried again for almost two hours. These accounts indicate that there are times when death of a patient is perceived by the students as a very difficult moment. Arguably, this illustrates the difficulty with which students have to manage their emotions under such circumstances and this is consistent with James (1993) who asserts that emotional labour can be described as 'hard work' and even 'sorrowful.' However, this does not happen with every death, but where the student perceives that there was a good relationship with the patient and also if the student did not expect the patient to die. This is consistent with Smith (1992) who indicates that some of the difficulties of managing emotions around death and dying have to do with its unpredictability.

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<sup>168</sup>CD4 count is a test which measures the number of T helper cells (T lymphocytes) in a patient who is HIV positive. This helps to determine the strength of the patient's immunity and progression to AIDS is diagnosed in adults when the CD4 count is less than 200 cells/mm<sup>3</sup>

It is also interesting to note the different reactions of students to death and their success or failure at managing their emotions. The two students whose accounts are mentioned first seem to have successfully managed their emotions, averting displaying sorrow as a nurse while one of the students actually cried expressing her sorrow. The student, who felt like crying but did not because she knew that she is nurse, demonstrates awareness of professional 'feeling rules.' Penson (1990) argues against giving in to one's own feelings because it can make one to lose perspective of the supportive role. Bolton (2001) revealed in a study that nurses work to attain a balance between showing concern and care for the patient whilst also maintaining a professional demeanour. She identified three distinctive faces by which nurses present themselves throughout their day to day work experience and these include a professional face, a smiley face and a humorous face. The student who did not cry successfully managed her emotions in order to display a professional face and I would argue that the student who cried exemplifies unsuccessful emotion work. A smiley or a humorous face would be inappropriate during such times but a professional face conveys a sense of being in control of the situation.

There is also evidence of tendencies to detach emotionally among students and this relates to caring for the terminally ill or dying patients. One of the students reported that whilst in year one, she perceived death of a patient as the most stressful thing and it was also demotivating. As a novice student she felt that when care is rendered, the patient has to improve and when the patient died, the student felt stressed holding herself accountable and attributing the death of the patient to an omission in the care given. As a result of this, the student reported that she started avoiding caring for the terminally ill patients, dreading the stress that would follow should the patient die. This reveals how over involvement can lead to eventual detachment. Debatably, I refer to this as a case of over involvement because the student demonstrates the failure to 'let go' by holding herself accountable for the patient's outcome. Carmack (1997) revealed in a study how participants in her study balanced engagement with detachment by not feeling responsible for the outcome. What particularly stressed the student was seeing oneself as being responsible for the outcome hence the tendency to analyse what was done for the patient. This seems to

be an experience which is specific for novice students. Nevertheless, these findings provide significant insight on the issue of death and dying and its impact on students' clinical experience. Students should be supported so that they can learn to balance engagement and detachment and Carmack reveals that this is possible by learning to 'let go of the outcome.' Students should feel contented knowing that they can make a difference through care giving regardless of the outcome and they should also learn to accept their limits.

## CHAPTER 9: CONCLUSIONS AND RECOMMENDATIONS

*Research aimed at an appreciation of student learning activities in the clinical area is necessary before any improvement of the quality of the learning may be intelligently proposed (Polifroni et al 1995:163)*

### 9.1. Chapter overview

In this final chapter I summarise the research findings and discuss recommendations to improve clinical learning in Malawi. Although the study took place at KCN, some of the findings may apply to pre-registration nursing programmes offered by other educational institutions. Presumably, what I portray in this study could be shared experiences which students from other institutions could identify with. The study findings reveal the prevailing problems in clinical nursing education and some of the proposed recommendations discussed are derived from what students suggested as they gave account of their clinical learning experience. Nursing students are the 'insiders' where clinical learning is concerned and their views should inform any meaningful innovation. Some of the proposed recommendations are largely influenced by my personal knowledge which is justifiable for a hermeneutic phenomenological study because of the role the researcher's foreknowledge plays in promoting understanding of the phenomenon being investigated and I believe this should also inform the recommendations for improvement.

### 9.2. Summary of research findings

The study reveals that that clinical learning for KCN students is an experience suffused with emotions and emotional labour (Hochschild 1983) is inevitable. What enabled me to capture such a conceptualisation of the clinical learning experience for KCN students was my increasing knowledge and awareness of the reality of emotional labour. I was able to see the meaningfulness of emotional labour (Hochschild 1983) as a conceptual framework to interpret the students' accounts of their experience and, by so doing, arrive at a new and unique conceptualisation of clinical learning for KCN students.

The study reveals that some of the challenges which KCN students encounter during clinical placements are related to the structural problems prevalent within the CLE

and these include severe nursing shortage and gross lack of supplies. The severe nursing shortage and high patient turnover increase the workload within the clinical settings. Therefore, clinical nurses perceive the presence of students in the clinical area as a time when they can have respite and they waste no time in letting students know about this. The statement, 'we cover shortage' was a constant theme which students expressed and this portrays that inadvertently they are a 'potential workforce' and this reflects their vulnerability. This also compromises clinical learning because more commonly patients' needs take primacy over their learning needs. The gross lack of material resources also negatively impacts on students' clinical learning. Students reiterated that they learn most of the nursing procedures through improvisation and a theory-practice gap is a concern which was also commonly expressed. The theme, 'learning in a hard way,' eloquently conveys the students' learning difficulty.

Generally the study portrays lack of support to students during clinical placements. Most likely the severe nursing shortage is responsible for this but this is also attributed to negative attitudes which some of the nursing personnel display towards KCN students. Apparently, this seems to be quite a common problem and it is associated with the fact that KCN students are pursuing a bachelor's degree, a qualification which most of the practicing nurses do not possess. In some clinical settings the psychosocial atmosphere appears oppressive and hostile and sometimes students are shouted at. Absenteeism and abscondment are some of the distancing or detachment strategies which students employ when allocated in such clinical settings in order to protect their emotions. However, it is quite explicit from the study that KCN students also have their own share in these relational problems. The relational problems engender unwillingness to teach which implies that few nurses may be available to support students' learning. In addition, KCN lecturers also fail to effectively support students during clinical placements. Accordingly, students mentioned of 'learning on their own,' with peers being the only form of support readily available. The statement, 'lost sheep,' which was coined by one of the students, demonstrates the students' predicament. Generally, the study reveals lack of leadership for nurse learning in practice.



The study reveals that the student-lecturer interaction in the clinical setting is also problematic. The infrequent visits to the clinical area by KCN lecturers hinder the development of student-lecturer relationships. Students do not get acquainted to lecturers and their presence in the clinical setting induces stress among the students. Some lecturers employ clinical supervision approaches which are characterised by shaming practices and they demean students' self-worth. Consequently, students distance themselves from such lecturers in order to protect their emotions and this hinders fruitful meeting which can facilitate clinical learning. However, despite the role failure, students' accounts clearly indicate preference to be taught during clinical placements by lecturers through hands-on-care so that they can learn the ideal nursing practice. Students also reported that the presence of a lecturer in the clinical setting encourages and motivates them to learn which confirms occurrence of positive encounters. The study also reveals that in clinical learning just like in patient care, it is the 'little things' that matter. Students' narratives indicate that they prefer lecturers who are approachable, friendly and they should approach them with smiling and welcoming faces and not with gloomy faces. If the lecturer-student interaction in the clinical area will be fruitful towards promotion of clinical learning, it remains that lecturers should engage in emotional labour.

Assessment of students' clinical competence is also another challenge which students encounter. Ward sisters and nurse lecturers are responsible for student assessment at the end of a clinical placement but ward sisters are the ones who play a key role in these assessments because it is assumed they have better knowledge of students' performance. However, it appears that neither the ward sisters nor the nurse lecturers are in a better position to assess students because they lack knowledge on how students perform because of not closely working with them. Consequently, interpersonal relationships significantly influence the assessment process and the students repeatedly mentioned that the assessments are biased. It is not surprising that students' narratives reflect how they develop strategies to build good relationships with clinical nurses knowing the impact of such relationships on the clinical grade. I interpret such actions as trading and negotiating for good clinical grades and in such efforts emotional labour is portrayed.

The study also portrays a possibility of burnout among some of the nurses. This is exemplified by less than ideal practice which some of the nurses exhibit and I would attribute this to the labour situation within the clinical settings in Malawi. Some of the nurses seem to have lost the passion with which they entered nursing and there is evidence of negligence and unprofessional conduct. Indisputably, working as a nurse in Malawi appears to be extremely challenging. I would contend that for the nurses to be able to provide compassionate care and for them to be able to display a professional demeanour of smiling nurses emotional labour is essential.

### **9.3. Transforming nurse learning in Malawi**

In this section of the thesis I discuss the proposed recommendations which would help to improve nurse learning in Malawi. Initially I reflect the identified problems and then discuss possible ways of resolving them. Häggman-Laitila et al (2007) indicate that the development of clinical supervision is a mutual challenge to the health care organisations and nursing educational institutions. Consistent with this view, the study depicts problems which relate to the two stakeholder organisations and students also have their own share of problems. The study reveals that problems within the teaching hospitals in Malawi negatively impact on the professional socialisation of nursing students. The problems include shortage of nurses, lack of essential supplies, negative attitudes and lack of willingness to teach students which some of the clinical nurses exhibit. Problems related to KCN as an educational institution include inadequate student support and impersonal approaches of clinical supervision which some of the lecturers employ. Student related problems include negative attributes which some students display such as laziness among others and tendencies of absenteeism and abscondment which the study reflects. In addition, the study demonstrates that students fail to negotiate for their learning such that patient care takes priority over their own learning.

Transforming clinical learning in Malawi requires interventions which will target all the various problematic areas. Most of the identified problems for example lack of material resources and shortage of nurses are structural in nature and might require long-term solutions which are beyond the scope of this discussion. However, it is possible to intervene over problems related to process issues of clinical learning and this is the focus I propose to utilise in describing the recommendations to transform clinical learning for nursing students in Malawi. Some of the problems which affect clinical learning as the study findings illustrate are linked to emotions and can be resolved with short term solutions. The problems broadly fall within caring-learning relationships with students, qualified nurses, lecturers and patients being the main stakeholders involved. The main aim is to transform clinical learning through positive emotions and other relevant strategies which will maximise clinical learning. The proposed recommendations are discussed under the following themes; emotional

learning, passion centred teaching, innovative clinical supervision, reflective learning, assessing students' clinical competence effectively and student empowerment.

### **9.3.1. Emotional learning**

Evidence of emotion work from the students' accounts supports the assertion by Hunter and Smith (2007) that health care work is by its nature an area suffused with emotions. The study reveals that KCN students experience a unique dimension of emotional labour because of problems prevalent in the clinical settings where they gain their clinical practice experience. Students are shouted at in some clinical settings by both clinical nurses and even lecturers sometimes making the CLE quite hostile and oppressive. All these factors are linked with unmanaged emotions and suggest the need for emotional learning. This will enable clinical nurses and lecturers learn to manage their emotions and to be able to induce or suppress feelings as appropriate while interacting with students during teaching and learning encounters. This will also help the clinical nurses to manifest a professional demeanour which conveys care and compassion to patients as opposed to mistreating them communicatively. According to Fredrickson (2003:164), 'the bottom-line message is that organizational members should consider cultivating positive emotions in themselves and others, not just as end states in themselves, but also as a means to achieving individual and organizational transformation and optimal functioning over.' Emotion management can therefore help various health care personnel in Malawi to cultivate positive emotions which will positively impact patient care and clinical learning. Sylwester (2000) indicates that understanding the importance of emotions and feelings is crucial to effective teaching and learning.

Goleman (1996) claims that as human beings we have two minds and these include a rational mind which thinks and an emotional mind which feels and Freshwater and Stickley (2004) reflect that these two minds are both significant in nursing. The two authors claim that it is with the rational mind that an individual attends to the technical aspects of nursing procedures, while it is the emotional mind which perceives the emotional needs of the person at the receiving end of care. This further justifies the need for emotional learning among health care personnel and student nurses in Malawi. Froggatt (1998) indicates that some emotions such as anger can be dangerous hence the need to manage them. I would also add that unmanaged emotions which are manifested through shouting at patients as this study reveals can

be detrimental to patients' well-being. Smith (1992) claims that emotional labour is essential in nursing because nurses are expected to be emotionally caring and to display emotions that convey care and compassion.

This discussion therefore is aimed at reflecting how emotional learning can be appropriated which would contribute significantly towards the creation of a positive CLE and improving patient care. Various approaches could be utilised to effectively introduce emotional labour within nursing education and practice in Malawi.

However, the best approach as Freshwater and Stickley (2004) advocates would be to incorporate emotions into the nursing curriculum so as to produce emotionally intelligent practitioners. Freshwater and Stickley (2004:93) contend that 'education that ignores the value and the development of emotions is one that denies the very heart of the art of nursing.' Christiansen and Jensen (2008) identified in a study that role playing followed by peer feedback and group discussions are effective in enabling students to develop emotional learning. Role plays can provide an avenue for students to reflect on their practice if effectively used. However, Christiansen and Jensen suggest the importance of role play in emotional learning within the context of classroom learning. Arguably, role play can also be used during clinical placements during formal sessions planned to facilitate reflection. I would propose that role play can be used as an adjunct to reflective journal writing.

At practice level, Smith (2012) indicates that compassionate, committed and emotionally sensitive leadership is required to have compassionate and smiling nurses as this is a gesture of care for those who care. Huynh et al (2008) recommend that training workshops should be conducted for staff and McQueen (2004) suggests that the training should focus on self-awareness, self-regulation and social skills. Mazhindu (2003) also rightly claims that nursing practice cannot dissociate itself from the emotional dimension and she recommends that reflection on practice is the key to opening and exploring the emotional dimensional of caring. This is even supports the need for both students and practicing nurses in Malawi to be oriented to reflective practice.

Although emotional labour has a potential to positively impact on patient care and clinical learning, its negative consequences are well documented (Mann 2005). It causes estrangement between self and true feelings and burnout (Hochschild 1983). Furthermore Hochschild (1983) also argues that portraying emotions that are not felt creates the strain of emotional dissonance. McQueen (2004) claims that intense or continuous emotional work can be stressful and exhausting. Grandey et al (2005) asserts that higher degree of using emotion regulation on the job is related to higher levels of employees' emotional exhaustion. Higher levels of emotional labor demands are not uniformly rewarded with higher wages but the reward is dependent on the level of general cognitive demands required by the job as such occupations with high cognitive demands evidence wage returns with increasing emotional labor demands; whereas occupations low in cognitive demands evidence a wage "penalty" with increasing emotional labor demands (Glomb et al 2004). In addition, there is also evidence that emotional labour can have negative consequences on health.

### **9.3.2. Passion centred teaching**

The main problems that relate to KCN as the educational institution include inadequate student support and impersonal approaches which some of the lecturers employ during clinical supervision. Lecturers' visits to the clinical area are intermittent and of a short duration. This hinders development of student-lecturer relationships to an extent that the presence of a lecturer in the clinical setting induces stress among students. The nature of student-teacher interaction determines whether learning will be facilitated or not. To this end, Gillespie (2005:213) wrote, 'how can we meet students in a manner that ensures the fruitfulness of teaching-learning interactions?' My study reveals that students prefer lecturers who are friendly and interact with them in a manner that maintains their self-worth. Consistent with Gillespie (2002) this raises the issue of student-teacher relationships and suggests a trend towards a humanistic approach to teaching. However, Spurr et al (2010) contends that developing student-teacher relationships does not guarantee a successful learning environment. In view of this, I would propose that in order to transform clinical learning at KCN, there is need to move beyond just focusing at the student-lecturer relationship. This calls for the KCN faculty to adopt a passion centred philosophy to clinical teaching and learning. Passion transcends beyond relationships in that it involves caring and I believe it would significantly help to transform clinical learning at KCN.

Passion is a driver, a motivational force emanating from the strength of emotion (Day 2004:11). Passion centred teaching philosophy in clinical nursing education implies that nursing faculty would have a passion for the students and a passionate belief that who they are and how they respond and interact during teaching sessions can make a difference in the lives of students (Day 2004; Spurr et al 2010). Spurr et al (2010) contend that this can lead to development of positive learning environments for student nurses where they can be supported, valued and engaged. Day (2004) further claims that passion is linked to enthusiasm, caring, commitment and hope. Debatably, the passion centred philosophy to teaching and learning would rekindle enthusiasm for supporting students during clinical placements. As Day (2004:427) posits, being passionate generates energy, determination, conviction, commitment



and even obsession in people. Day cites Fried (1995) who claims that passion is discoverable, teachable or reproducible and this makes adoption of a passion centred philosophy to nursing education feasible. Spur et al (2010) implemented a passion centred teaching philosophy within nursing based on the seminal work by Day (2004). Their framework consisted of the following qualities: passion for achievement, care, collaboration, commitment and trust. They claim that these form cornerstones of a philosophical approach to leadership and teaching in clinical nursing education and a similar approach would be used for KCN.

### **9.3.3. Innovative clinical supervision**

The study also reveals that clinical supervision by KCN lecturers is minimal and lacks a proper structure mainly being conducted in ad hoc manner. Such type of clinical supervision cannot facilitate meaningful learning and this explains why most of the students I interviewed reported that their learning is self-initiated. It is important to formalise and structure clinical supervision to effectively facilitate clinical learning. Koh (2002) suggests that student support by nursing faculty maybe in three forms and these include teaching by engaging in hands-on-care, facilitation of learning through structured learning activities arranged to occur during the clinical experience and through reflection. It would be necessary for KCN lecturers to plan and structure their visits to the clinical area in such a way that their approach to clinical supervision incorporates these three aspects. Without any model to guide the facilitation of clinical learning, the process is bound to be haphazard and the students may not learn due to the complexity of the CLE which is clearly documented in literature (Papp et al 2003; Brown et al 2005; Edgecombe and Bowden 2009).

Sloan and Watson (2002:41) state that there is a diversity of supervision models in literature and they define a supervision model as a conceptual framework which can assist in the delivery of clinical supervision. Budgen and Gamroth (2008) conducted an analysis of existing literature on practice education models and identified ten models which are currently being used in nursing to facilitate clinical learning. The models are as follows; faculty supervised practicum, preceptorship, education units, joint appointment, secondment, affiliate position, internship, cooperative education, work-study and undergraduate nurse employment. Sloan and Watson (2002) indicate that the onus to decide on the choice of framework for clinical supervision is on those that engage with it. Therefore, as one of the KCN faculty members responsible for clinical supervision of nursing students, it is befitting that I propose some possible models that can be used to facilitate clinical learning. However, initially I wish to discuss some salient issues identified in the study which may guide choice of the appropriate models.

The study reveals that KCN students prefer that lecturers should teach them through provision of hands-on-care. This implies that in Malawi facilitation of clinical learning should be a shared responsibility where both lecturers and clinical nurses should actively take part. This is important because of the rampant nursing shortage in Malawi which would hinder clinical nurses from effectively facilitating students learning if the responsibility is entirely left to them. Webster W1990) reminds us of the primacy of patient care to clinical nursing staff and that in sharing our teaching responsibilities with them we should ensure that we do not demoralise them or lose their co-operation. Similar sentiments are echoed by Ioannides (1999) who indicates that as we share teaching responsibilities with clinical staff, it is worth questioning whether they have the time, motivation and ability to help the nursing students apply knowledge to practice. Literature reflects dichotomous views regarding the role of nurse teachers where some authors advocate for a clinical orientation (Webster 1990; Charlesworth et al 1992) and others support that nurse teachers should develop as educationalists (Osborne 1991; Acton et al 1992; Gerrish 1992; Forrest et al 1996; Rolfe 1996; Henderson 2011). I would propose that in Malawi it would be appropriate for lecturers to embrace both views. However, this does not mean that they should be extensively involved as practising clinical nurses, but rather that they should sometimes teach students through direct patient care which students prefer, and at the same time they should also utilise their educational expertise to provide educational support to clinical nursing staff to enable them to effectively support students. The study also reveals that students significantly contribute to each other's learning and this is a resource worth tapping on and should be considered in the selection of a practice education model.

The foregoing discussion reflects that the models which could be appropriate for facilitation of clinical learning for KCN students should be such that there is involvement of the lecturer, clinical nurses and students. Two practice education models identified by Budgen and Gamroth (2008) could be feasible for implementation at KCN and these include faculty supervised practicum and dedicated education units (DEU). It is appropriate to implement more than one model because no single model of clinical supervision is suitable for all nursing contexts

(Fowler 1996). The preceptorship model could also have been a possible alternative but its feasibility is doubtful due to the severe nursing shortage and the high student intake. The faculty supervised practicum is already being implemented in some ways but there is need for improvement. The model involves assigning a faculty member to work with a group of students in an area of practice where the faculty member has expertise (Mannix et al 2006). Students and faculty work on the unit for several hours and are responsible for patient care. It is not always possible to find a faculty member with the required expertise but at least availability of a KCN faculty member can be guaranteed. Budgen and Gamroth (2008) indicate that the key feature of the education unit is that practice education takes place on a unit where education is equally a primary goal as is patient care. Debatably this in itself is a step towards establishing clinical settings into learning organisations and it is one of the ways of promoting positive learning environments.

Day (2004) revealed that among other factors, passion is associated with creating environments that promote excitement to learn. Students can be motivated to learn as they encounter different models of facilitating clinical learning. Another way reflected in literature to formalise and give structure to clinical learning is to manage student learning using patient pathways (Pollard and Hibbert 2004). This refers to allowing students to learn by following patients' care journeys (Pollard and Hibbert 2004; Hutchings and Williamson 2005). It is a journey the patient takes from admission to discharge and includes the diagnostic procedures, therapeutic interventions, nursing care in the ward, rehabilitation and follow up care. This exposes the student to other professionals and departments outside the ward and expands student learning thereby improving the quality of the learning experience. This also makes clinical learning more enjoyable, stimulating and inspirational (Hutchings and Sanders 2001).

The study also revealed that some nurses are not willing to teach students. This is a problem which needs to be dealt with in the creation of clinical environments that are conducive to learning. Henderson (2011) points out that leadership namely, ward/unit managers play a vital role in the creation of learning environments.

Similarly, Andrews et al. (2006) assert that ward managers as 'gate keepers' have a responsibility of establishing an environment that welcomes learners and assist staff to develop behaviours that facilitate learning in the clinical area. Henderson (2011) claims that these local leaders are instrumental in shaping the motivation of teams to support learning. In view of this, KCN needs to collaborate with the various ward/unit managers and encourage them to motivate clinical nurses to take a positive stance in teaching students. Henderson also proposes that through demonstration of effective leadership behaviours such as open communication, sharing knowledge and ideas, ward managers can influence other clinical nurses to interact in a positive manner that promotes learning. One of the factors which seem to be the reason behind the unwillingness to teach students is the remuneration of selected clinical nurses who are recruited as mentors. As the study reveals, nurses who are not recipients of the remuneration package become unwilling to teach students. This is not necessary because preceptoring students is an obligation registered nurses have in conjunction with other daily assignments (Hallin and Danielson 2010) and the practice should be abandoned in order to solicit the commitment of all nurses.

#### **9.3.4. Reflective learning and practice**

KCN students do not engage in reflective learning because they lack proper guidance and there is no provision of formal opportunity to allow them to reflect on their clinical experience. They possess reflective logs but these are not used to promote reflection because the entries mostly include objectives which they plan to achieve. Guided reflection helps students to contextualise and conceptualise new information (Dix and Hughes 2004). Pierson (1998) indicates that reflection encourages students to become thoughtful individuals, capable of critical and innovative thinking and this is one of the goals of nursing education at KCN. The critical and thoughtful approaches are essential for providing nursing care in complex and challenging environments as is the case with Malawian hospitals. Baker (1996) indicates that reflection leads to increased sensitivity to the environment and would make the students question whatever is a puzzling experience. The challenging nature of the clinical learning experience implies that KCN students do encounter puzzling experiences and without reflection it is possible that potential learning opportunities are lost. Horton-Deutsch and Sherwood (2008) also assert that reflection has a potential to prepare emotionally competent nurses leaders.

In order to enhance the development of critical thinking skills nursing faculty need to be reflective themselves. Being a reflective teacher implies thinking about one's teaching, modelling reflective thinking strategies in the classroom or clinical practice and using specific teaching strategies that encourage students to be reflective (Scanlan and Chernomas 1997). As the study reveals, reflection appears to be a new concept to both students and practitioners in Malawi and they need to be oriented. Literature indicates that it is the responsibility of nurse educators to teach students and practising nurses the art of reflection (Owen 1993; James and Clarke 1994). This is an area where KCN faculty can exercise their educational expertise by modelling and facilitating reflection among clinical nurses as well. There are some innovative teaching strategies which KCN faculty can adopt to promote reflection among students and these include; reflective practice groups (Platzer et al 2000), learning diaries (Heath 1998), action learning sets (Graham 1995) reflective journal writing (Baker 1996) and critical incident analysis (Parker et al 1995).

Fowler and Chevannes (1998) indicate that reflection is an important and integral part of clinical supervision. This implies that KCN faculty have to provide formal opportunities to students within the planned clinical teaching activities to support them through guided reflection. In support of this view, Pierson (1998) maintains that providing student nurses time to reflect-on-action is an important consideration for nurse educators. Burrows (1995) argues that most generic nursing students, by virtue of their age, lack cognitive readiness for reflective thinking and therefore recommends nursing teachers to introduce students to reflection using simple strategies before moving to complex frameworks. Some of the possible frameworks which students could be oriented to in order to facilitate reflection include the reflective cycle by Gibbs's (1988) and Driscoll' (2000) model of reflection(see Appendix H).

### **9.3.5. Assessing students' clinical competence effectively**

The way the assessment of students' clinical competence is conducted at KCN, it is unlikely that assessment goals are achieved. Clinical evaluation has two interrelated functions which are achieved through formative and summative evaluations respectively. First and foremost clinical evaluation is intended to provide feedback to students and teachers on what learning has taken place and what is required to improve the teaching-learning process (Mahara 1998). Secondly, clinical evaluation is aimed at making a definitive judgment whether the student's practice meets the professional or the academic requirements (Mahara 1998). The way KCN students are assessed, it is doubtful if all they all meet the set standards. Interpersonal relationships greatly influence the outcome of the assessments and the whole process appears to be quite subjective. The study findings confirm the assertion by While (1991) that the main challenge in clinical evaluation lies in the subjectivity of the observational process and also support the assertion that assessment of students' clinical practice is a difficult issue (Toohey et al 1996; Chambers 1998; Mahara 1998; Andre 2000; Neary 2001).

The use of checklist of competencies and OSCE indicates that the clinical evaluations at KCN mainly involve assessment of psychomotor skills. Intellectual abilities such as critical thinking and analysis and affective skills are not assessed. Seale et al (2000) maintain that student assessment in clinical practice needs careful consideration as it has a motivating effect on student learning and this current study portrays students being demotivated because of biased assessments. There is need to incorporate other assessment strategies so that the tools in use should be capable of assessing students' intellectual abilities, psychomotor and affective skills. Toohey et al (1996) identified five models of assessment of the practicum which include the attendance model, the work history model, the broad abilities model, the specific competencies model and the negotiated curriculum model. Redfern et al. (2002) recommends that these models may be relevant for assessing competence in nursing and other related professions.



Toohy et al (1996) provides a description of each of the models and how they can be used to assess students' competence which makes adoption of the models a possibility. The attendance model has its emphasis on attendance at the placement and there is no formal assessment but the workplace supervisor attests whether performance is satisfactory or not. The work history model is aimed at assisting the student to document significant tasks that they have undertaken in the course of the practicum and also to reflect on what they have learnt and a log book or a journal is used to promote reflection. The broad abilities model is an assessment model where abilities that the programme aims to develop in the student are specified and the assessment focuses on such abilities. Examples of the abilities include intellectual abilities such as critical and analytical thinking and interpersonal skills. The advantage of this model of assessment is that it promotes integration of theory to practice. In a specific competencies model the key roles and tasks on which the student is expected to develop competence in are identified and performance is assessed in the work place and criterion or norm referenced grading may be employed. Toohey et al (1996) indicates that the difficult with this assessment model is that the student might have problems to perform the assessment task. This is evident in this present study for example; students' accounts reflect that sometimes they have problems because some nurses refuse to observe and assess their competence on specific procedures. The negotiated curriculum model is assessed through a learning contract and there should be an agreement on the learning objectives which the student aims to achieve and the relevant activities.

A critical analysis of the models by Toohey et al (1996) reflects that they do not only assess for competence with technical skills but some of the models can be used to assess intellectual abilities and even humanistic aspects of nursing such as affective skills and interpersonal skills. Literature reflects that validity and reliability of tools used to assess students' competence is a major concern. However, Toohey et al (1996) recommend that institutions can benefit from combining elements from different models and I believe this would help KCN overcome some the problems discussed earlier on. Calman et al (2002) claim that recent methods of assessment involve continuous observation and reflection on practice and it appears reflection

has been the main missing component for the various strategies of assessment utilised at KCN. The models of assessment by Toohey et al (1996) require either observation or reflection.

I would therefore propose that KCN should utilise a combination of the models by Toohey et al (1996) to assess students at different levels of the programme which could also help to assess for progression. For example the specific competency model could be used to assess performance from year one to year three of the programme but there is need to develop specific competencies that should be achieved during each year of study. In year one, students do not have much exposure to the clinical area and the emphasis is on helping them to develop some nursing skills appropriate for their level. In view of this, their assessment could also include OSCE to assess the basic skills. In year two students learn to take care of patients with various medical or surgical conditions, therefore it would be appropriate that assessment of competence should also include a case study. Calman et al 2002: 523) claim that the practice portfolio and care study are indirect assessments of competence that rest upon the questionable assumption that the quality of the student's written work reflects their performance in practice. This present study reveals that for such an assumption to be true, the lecturer should closely follow the student to ensure that what is documented was indeed practiced. An OSCE would also be appropriate for second year students because there is still emphasis on mastery of nursing skills. In third year assessment of competence could include the work history model where students would be required to document specific tasks that they have done and what they have learnt in a log book or journal. The aim with such an assessment model would be to introduce students to reflective learning whilst they are in third year of their studies. Toohey et al (1996) claim that the work history model offers a way of documenting diverse student experiences and this would require students to collate data regarding their learning in the practice setting which can be used reflectively or provided as evidence in their portfolio of practice (Hutchings and Sanders 2001:40). Finally, assessment of competence for year four students could include the broad abilities model and the negotiated curriculum model. This is important because in year four students' experience includes a

preceptorship programme which implies that the specific abilities intended to be achieved through the preceptorship programme should be identified. The negotiated curriculum model is also important because by fourth year the student should be aware of possible areas of deficiencies and therefore can decide on the learning objectives to be achieved and activities to be undertaken and the assessment could be performed through a learning contract. Toohey et al (1996) maintain that this model of assessing competence engenders high commitment and motivation among students.

Some of the problems encountered during assessment of clinical competence seem to be related to lack of knowledge on assessments by clinical nurses. Therefore, training of qualified nurses for the role of assessors could also be a form of support to be given to clinical nurses. Calman et al (2002:520) suggests that the training could focus on the following; students' programmes, the clinical competence assessment tool and basic principles of teaching and assessment.

### **9.3.6. Student empowerment to maximise clinical learning**

The study reveals that during clinical placements students fail to achieve their learning outcomes because nurses relinquish most of their responsibilities to them. Consistent with Andrews et al (2006: 869), the study reveals that a definitive preparation to help students develop constructive ways to maximise learning opportunities is lacking. Elcock et al (2007) recommends that students need to be appropriately prepared for learning in, from and through practice with guidance on how to use supernumerary status to maximise their learning. They further point out that students need to be equipped with a range of skills that will allow them to take charge of their own learning in practice just as they are taught study skills in university to undertake academic learning. Assertiveness is a skill that can help students to be able to negotiate their learning needs (Begley and Brady 2002; Gray and Smith 1999) and Dunn and Hansford (1997) revealed in a study the importance of students' assertiveness in ensuring their own best learning.

Papp et al (2003:266) assert that the clinical environment can be divided into two separate environments namely, the learning environment and the nursing environment. They further state that the clinical environment is foremost a nursing environment and only after that something else. They indicate that students function in the two environments and with this view I would propose that students' engagement with the clinical environment could be seen to be on a continuum with working and learning at the two ends of the continuum. The students' own attributes such as assertiveness to negotiate for own learning determines whether the clinical placement will be more of learning or working experience.

The study findings also reveal that some students tend to relax, abscond and fall into a non-learning mode when they are not supervised. Of course the study also reveals that there are other factors that cause students to abscond such as poor relationships with clinical nurses where students employ distancing strategies to protect their emotions. However, I would contend that this reflects the students' shortcomings because it is an inappropriate way of responding to a problem. Students need to utilise strategies of resolving problems that are befitting for adult learners. I would

therefore propose that beginning students should be oriented to what being an adult learner entails.

In view of the existing problem of inadequate support to student nurses during clinical placements, there is need to move towards student centred or self-directed clinical learning. This means student nurses should be actively engaged in managing their own clinical learning and this requires that pedagogic approaches to clinical teaching and learning should be avoided. Spencer and Jordan (1999:1281) define self-directed learning as, 'when students take the initiative for their own learning: diagnosing needs, formulating goals, identifying resources, implementing appropriate activities, and evaluating outcomes.' Spencer and Jordan (1999) claim that self-directed learning is an active process which encourages deep approaches to learning. It is a learning strategy based on the principles of adult learning. However, there is evidence that not all students are self-directed and that novice students prefer teacher centred models which might hinder successful implementation of such learning approaches. Problem based learning (PBL) is one of the learner centred approaches reflected in literature and this is a strategy which KCN is already utilising. What might be required would be to implement the PBL within the framework of clinical nursing education. Peer mentorship programme is also an alternative approach of fostering professional development among student nurses during their clinical experiences (Yates et al 1997; Hughes et al 2003; Goldsmith et al 2006) and KCN could utilise this approach to formalise peer support.

### **9.3.7. Areas for Further research**

There are several possible areas for further research. For example, clinical nurses and KCN lecturers are also key stakeholders who significantly influence clinical learning. However, this study only explored the students' views and there is need to extend the study in order to explore the views of lecturers and clinical nurses on clinical learning.

Students' narratives portray their conceptualisation of care but they fail to articulate the nuances of care within the Malawian perspective. There is need for further research to identify what compassionate care entails within a Malawian culture.

The study reveals the impact of nursing shortage on patient care and nursing education. The severe nursing shortage within health care settings in Malawi occurred as a consequence of migration of nurses to the UK and other western countries. Locally within Malawi there has also an exodus where quite a considerable number of nurses left bedside nursing to work in non-governmental organisations. There is evidence that the problem of nurse migration has been resolved. However, there is need for further research to determine the intent to migrate among the practicing nurses and also to establish if the retained nurses are committed and emotionally engaged otherwise the strategies which have put in place to curb nurse migration and retain the nurses would be deemed futile.

The study portrays unprofessional conduct among some of the clinical nurses and I attribute this to burnout. Some of the nurses seem to be severely affected by burnout while others appear to be committed and have maintained their passion for patient care. Further research is required to explore the problem of burnout and to identify factors which may have helped other nurses to retain their passion for nursing. The findings could inform policy on retention of nurses.

### **9.3.8. Concluding Remarks**

Nursing is a practice based profession which makes clinical nursing education a core component of the curriculum for pre-registration nursing students. The preparation of nursing students for their role as future nurses is a shared responsibility between nursing educational institutions and healthcare organisations with the clinical setting playing a crucial role in their professional socialisation. This study reveals that problems within the clinical settings negatively impact on students' learning and in Malawi the main problems are severe nursing shortage, gross lack of material resources and lack of an environment which supports students' learning. The study also reveals that in Malawi it is not only clinical nursing education which is at stake but nursing practice as well. Therefore, this study has implications for both nursing practice and nursing education and the proposed recommendations are intended to bring innovation to these two aspects of the nursing profession. Collaboration is required between KCN as the educational institution and the health care organisations in order to effectively implement the proposed recommendations. These proposed strategies for innovation will help in the establishment of positive clinical learning environments and foster the development of compassionate care within health care settings thereby making a difference to the provision of care. I would finally conclude that these findings contribute to nursing knowledge on emotions in the context of nursing education and practice within an African cultural perspective.

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## **APPENDICES**

University of Edinburgh  
School of Health in Social Science  
Nursing Studies



### **APPENDIX A: Guide for Conversational interviews**

#### **Research Title:**

Exploring the clinical learning experience: perspectives from Malawian undergraduate student Nurses.

#### **Note:**

These grand tour questions will guide the conversational interviews with participating students. Probes will be utilised where necessary.

1. What can you say about your clinical experiences as a learning experience?
2. What does a day's experience during a clinical learning experience constitute?
3. What clinical learning experiences stood out as memorable both positively and negatively?
4. What are some of the memorable encounters you have had with fellow students, nursing faculty and clinical nursing staff during your clinical learning experiences?
6. What memorable encounters have you had both positively and negatively whilst caring for patients.

University of Edinburgh  
School of Health in Social Science  
Nursing Studies



## **APPENDIX B: Information sheet and Informed Consent form**

### **Research Title**

Exploring the clinical learning experience: perspectives from undergraduate students of Kamuzu College of Nursing

Dear Prospective Participant,

### **RE: Information Sheet for the Prospective Participant**

My name is Gladys Msiska, one of the faculty members at KCN, but presently I am a doctoral student at University of Edinburgh (UK). I am writing to request for your participation in a study titled, “Exploring the clinical learning experience: perspectives from undergraduate students of Kamuzu College of Nursing. “The study is aimed at exploring the nature of the clinical learning experience from the perspective of students and to examine the clinical learning experience against an experiential model. The study employs hermeneutic phenomenology as its research approach. Phenomenology is the study of lived experiences whereas hermeneutics has to do with interpretation of narrative accounts of the experience. Hermeneutic phenomenology therefore involves obtaining thick descriptions of the experience through conversational interviews. The interviews follow a dialogic approach and not question and answer format and this is important because it allows both the interviewer and interviewee to be immersed into the discussion so that meaning of the phenomenon under investigation can be attained. In a hermeneutic phenomenological study, the participant is a Co-Researcher and this also allows

understanding of the phenomenon to emerge from the concern of two people committed to exploring the experience of one of them. A hermeneutical phenomenological study also requires that transcriptions should be returned to participants for validation and this is also done with the researcher's interpretation of the experience so that the participant should validate the findings. Should you accept to participate in this study, the transcribed interview will be sent to you within two days for your validation and the interpreted findings will be sent to you at a later stage. This promotes objectivity of the study.

The study is for the researcher's PhD thesis and you are being requested to participate in this study because you are one of the senior students at Kamuzu College of Nursing and therefore you have had a substantial clinical learning experience. It is believed that you have progressively learnt the issues and concepts which underpin nursing practice, beginning with fundamental issues and concepts which you must have attained in year one, to complex issues and concepts and that you can therefore be able to articulate your experience. Data collection will take place from November 2009 to January 2010 and your participation is voluntary. Should you accept to participate, you will be one of the twenty participants. You will be interviewed at a place of your own choice and our conversation might last up to two hours and the interview session will be tape recorded if you consent and nobody will be listening. You are not forced to answer all questions and you can withdrawal from participating even after the interview has already commenced and this will not be used against your academic progression.

Privacy and confidentiality will be ensured throughout the research period. Tapes of recorded interview sessions will have codes and not names in order to ensure anonymity. All research materials including the recorded tapes, notes taken during the interview and my reflective diary will be kept in a locked filing cabinet and the key will be kept by the researcher. My supervisors both here in Malawi and at University of Edinburgh are the only people who will have access to the data. However, the information produced during this research will be used for publication and presentations during research dissemination conferences. When the research is

completed, the raw data will be stored at a data archive (Research Centre KCN). This study is associated with minimal risks which could be psychological in nature and that such occurrences will be handled through appropriate counselling. The study is beneficial because it is hoped that the results will help to define clinical learning within a Malawian context. It will also provide feedback which might form the basis for improving the clinical learning experience. Should you accept to participate in this study you will be asked to give both verbal and written consent. If you have any questions about this study, you can ask the chairperson of COMREC or the head Medical-Surgical Nursing Department and their contact details are indicated below.

Prof J.M Mfutso-Bengo (Chairman COMREC)  
College of Medicine,  
Private Bag 360,  
Chichiri,  
Blantyre 3,  
Malawi.  
Tel 887245/887291  
Fax 874700  
Telex 43744

Gertrude Mwalabu (Head Medical-Surgical Nursing Dept)  
Kamuzu College of Nursing  
Private Bag 1  
Lilongwe

*Telephone:* 751622/ 751200  
Fax: 756424

University of Edinburgh  
School of Health in Social Science  
Nursing Studies



### **Informed Consent Form**

I understand that I am being asked to participate in a study which explores the clinical learning experience for undergraduate student of Kamuzu College of Nursing. If I agree to participate in this study, my role will be a co-researcher because of the nature of the study. I will be interviewed for approximately up to two hours and the interviews will be conversational in nature and will focus on my clinical learning experiences. The interview will take place where I choose and will be tape recorded. Codes will be utilised and no names will appear on all interview material. There are minimal risks associated with this study and these will be handled through appropriate counselling should they occur.

I realise that my participation in this study is entirely voluntary, and I may withdraw from the study at any time I wish.

I understand that all the study data will be kept confidential. However, this information may be used in nursing publications or presentations.

The study has been explained to me. I have read and understand the consent form, all of my questions have been answered, and I agree to participate. I understand I will be given a copy of the signed consent form

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher: \_\_\_\_\_ Date: \_\_\_\_\_

Further information is available from:

Name of Principal investigator: Gladys Msiska

Address: Kamuzu College of Nursing  
Private Bag 1  
Lilongwe

Telephone: 0888621797

Email: [gladysmsiska@yahoo.com](mailto:gladysmsiska@yahoo.com)

University of Edinburgh  
School of Health in Social Science  
Nursing Studies



**APPENDIX C: Letter seeking for permission**

The Principal,  
Kamuzu college of Nursing,  
Private Bag 1,  
Lilongwe,  
24<sup>th</sup> November, 2009.

Dear Madame,

**RE: Request to conduct a research study**

I am writing to report that my PhD proposal has been approved by COMREC and therefore I am requesting for permission to conduct the study. The study is titled, “exploring the clinical learning experience: perspectives from undergraduate students of Kamuzu College of Nursing.” The study will examine the student nurses’ perceptions of their clinical learning experience and an executive summary is attached.

The sample for the study will comprise of pre-registration nursing students and will be drawn from year three and year four student nurses who will be recruited non-randomly through volunteering. Data collection will take place from November 2009 to March 2010 and conversations interviews will be utilised. All the appropriate ethical requirements to ensure safety of the participating student nurses will be attended to.

A copy of the approval letter is also attached and all the appropriate ethical requirements to ensure safety of the participating student nurses will be attended to.

Waiting to hear from you soon.

Sincerely Yours,

Gladys Msiska (PhD Candidate)

Cc: Dean of Nursing Faculty, Registrar

## APPENDIX D: Timescale for the study

Clarifying research ideas										x			
Developing research aims and objectives											x		
Writing the introductory chapter												x	x
Experiential learning theory	x												
Literature review		x	x										
Methodological issues- Phenomenology and rigour in qualitative research				x	x								
Ethics submission – University of Edinburgh and making corrections						x							
Ethics submission – College of Medicine Malawi										x	x		
Pilot study												x	
Conversational interviews			x									x	x
Transcribing	x	X	x									x	X
Phenomenological analysis	x	x	x									x	X
Validation of data												x	x
Writing up			x	x	x	x	x	x	x	x	x	x	x
Writing up	x	x	x	x									
Conclusion					x								
Proof reading					x	x	x						
Submission								x					
Dissemination									x	x	x	x	x
<b>Months</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	





## APPENDIX E: Transcription symbols

Transcription symbol	What it symbolises
I:	A speaker identifier and stands for Interviewer
St-No-sex-yr	A speaker identifier. St: stands for student. No: stands for a number assigned chronologically indicating number of the interview session Sex is be represented by F or M depending on whether the participant was female or male respectively. yr: stands for year of study and is represented by 3 or 4 depending on whether the participant is in year 3 or 4 An example of a code using this speaker identifier is St-1-F-4.
+	Such a symbol within the transcript will symbolise a short pause
(.)	An empty parenthesis symbolise words which have been omitted to make the excerpt short while maintaining meaning
(laughter)	This symbol will symbolise laughter

## **APPENDIX F: Various Approaches to phenomenological analysis**

### **Framework for phenomenological analysis (Malawi study)**

1. Description of the clinical learning experience accomplished through conversational interviews with each participant.
2. Verbatim transcription of each interview session in order to develop phenomenological texts.
3. Return the transcribed description to the participant as soon as possible for validation.
4. Read and examine each interview text to identify expressions that reflect fundamental meaning of the text as a whole.
5. Return to each text reading line by line and extract phrases or sentences that directly pertain to the clinical learning experience. This leads to identification of themes and salient issues.
6. Read and reflect on the phrases and sentences and transform the meaning from concrete language into the language or concepts of the science. Try to spell out the meaning of each significant statement until fusion of horizons is achieved.
7. Identify patterns that emerge from the formulated meanings which lead to identification of clusters of themes or constitutional patterns
8. Identify all data that relate to already classified patterns to identify themes
9. Identify shared meanings by comparing and contrasting texts and the emerging themes
10. Integrate the findings into an exhaustive description of the clinical learning experience in such a way as to identify a fundamental structure.
11. Return to each participant for validation of findings

### **Colaizzi's procedural steps**

1. Read all the subjects' descriptions in order to make sense out of them.
2. Return to each description and extract from them phrases or sentences that directly pertain to the investigated phenomenon. The descriptions are known as protocols.
3. Try to spell out the meaning of each significant statement until fusion of horizons is achieved. This is known as formulating meanings.
4. Identify clusters of themes from the formulated meanings
5. Integrate the findings into an exhaustive description of the investigated phenomenon-
6. Formulate the exhaustive description of the investigated phenomenon in such a way as to identify a fundamental structure

**Source:** Colaizzi (1978:59-62).

### **Diekelmann's Phenomenological analysis**

1. All interviews were read to obtain an overall understanding
2. Interpretive summaries of each interview were written. Using MARTIN, each interview was coded for possible themes and a summary was written.
3. Selected transcribed interviews were analysed by the team. The investigator and the team members each prepared a summary of the transcribed interview and analysed for emerging themes. The analyses were read aloud and discussed.

4. Disagreements in interpretation were resolved by returning to the text. In some instances the participant was contacted for clarification. The principal investigator wrote a composite analysis for each text.

5. Through comparing and contrasting texts, the composite analyses themes that recurred and reflected the shared practices and common meanings were identified and described. The team was presented with this description and dialogue ensued.

6. As themes were compared, a constitutive pattern that linked the themes emerged.

Each constitutive pattern is present in all the interviews.

7. A draft explaining the themes and pattern with exemplars taken from the text was presented to the team and 2 experts outside the team. In addition, 5 faculty and 5 students who had participated in the study and 5 teachers and 5 students who had not participated in the study were also sent the draft. Responses and suggestions were incorporated into the final draft. Anything that was judged to be unsubstantiated in the text was deleted.


**Source: Diekelmann (1992:74)**

### **Giorgi's Phenomenological Analysis**

1. The researcher reads the transcription of the entire interview to get a general sense of the whole
2. The transcript is read again more slowly to get 'meaning units'
3. Transforming the subject's everyday expressions into psychological language with an emphasis on the phenomenon being investigated
4. Synthesis of transformed meaning units into a consistent statement of the structure

Note: This is not derived from Giorgi's original work

## APPENDIX G: Ethical approval documents

  
**UNIVERSITY OF MALAWI**

Principal  
Prof. R.L. Broadhead, MBBS, FRCP, FRCPCH, DCH

Our Ref.:  
Your Ref.: P.09/09/828

College of Medicine  
Private Bag 360  
Chichiri  
Blantyre 3  
Malawi  
Telephone: 887 245  
887 291  
Fax: 874 700  
Telex: 43744

19<sup>th</sup> November 2009

Mrs Gladys Msiska  
Kamuzu College of Nursing  
Blantyre Campus  
**Blantyre 3**

Dear Mrs Msiska,

**RE: P.09/09/828 - Exploring the Clinical Learning Experience: Perceptives from Malawian Undergraduate Student Nurses**


I write to inform you that COMREC reviewed your proposal which you resubmitted. I am pleased to inform you that your proposal was approved on 11<sup>th</sup> November 2009 after considering that you addressed all the issues which were raised in earlier reviews.

As you proceed with the implementation of your study we would like you to take note that all requirements by the college are followed as indicated on the attached page.

Yours Sincerely,

Prof J.M Mwatso-Bengo  
**CHAIRMAN - COMREC**

JMMB/ck



Nursing Studies  
School of Health  
University of Edinburgh  
Medical School  
Teviot Place  
Edinburgh EH8 9AG

Signature

Date 20/5/09

**8 Ethical consideration by School**

*The following section should be completed by the Head of School once the proposal has been considered by the School's research group.*

I confirm that the proposal detailed above has received ethical approval from the School [\* subject to approval by the external body named in section 6].

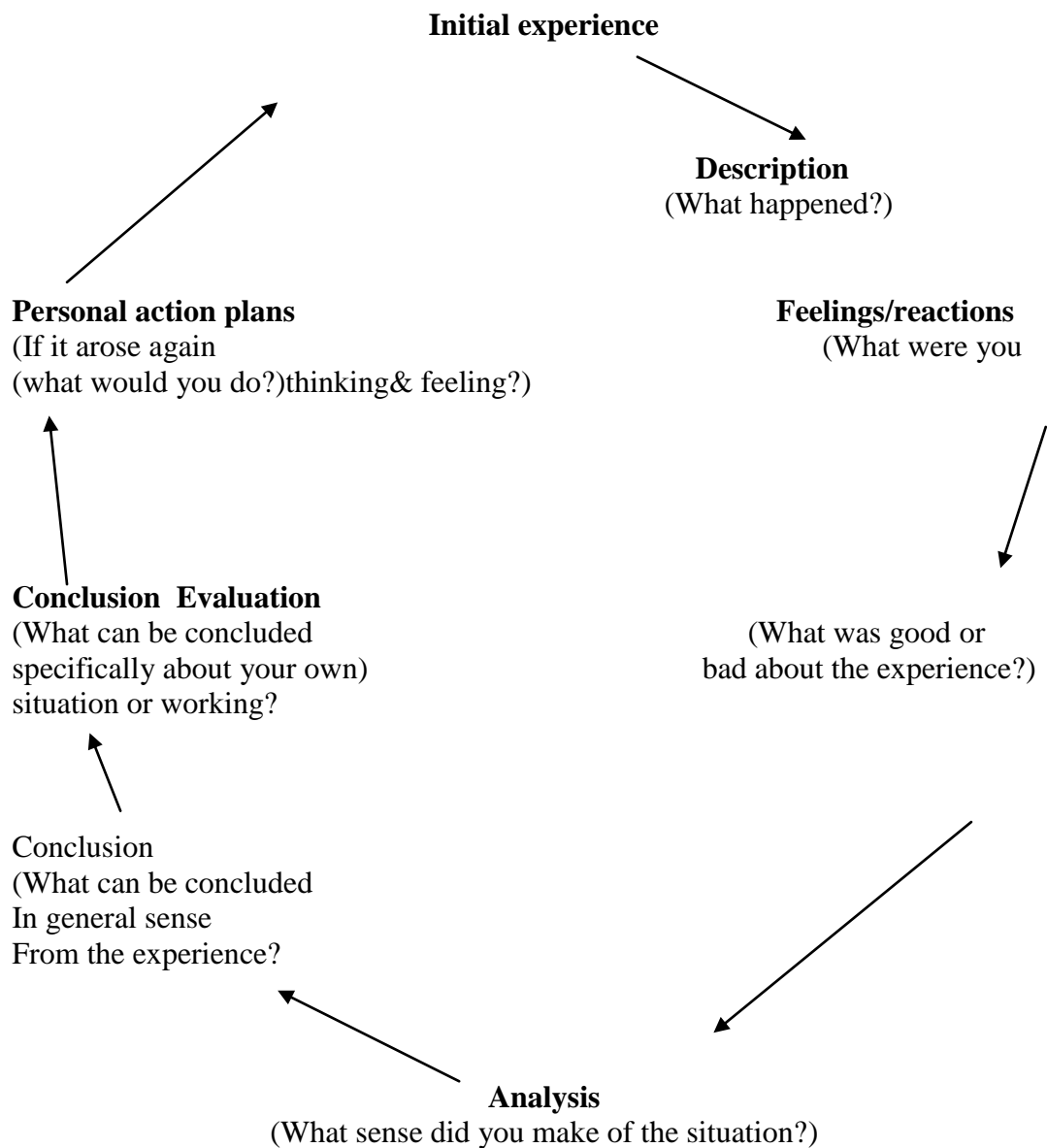
Signature

Date 4<sup>th</sup> June 2009

\* Delete as appropriate

## APPENDIX H: Frameworks for reflection

### Gibbs (1988) reflective cycle



Source: Gibbs (1988:47)

## **Driscoll's (2000) model of reflection**

### **1. A description of the event**

WHAT? Trigger questions:

- is the purpose of returning to this situation?
- happened?
- did I see/do?
- was my reaction to it?
- did other people do that were involved in this?

### **2. An analysis of the event**

SO WHAT? Trigger questions:

- How did I feel at the time of the event?
- Were those feelings I had any different from other people who were also involved at the time?
- Are my feelings now, after the event, any different from what I experienced at the time?
- Do I still feel troubled, if so, in what way?
- What were the effects of what I did (or did not do)?
- What positive aspects now emerge for me from the event that happened in practice?
- What have I noticed about my behaviour in practice by taking a more measured look at it?
- What observations does any person helping me to reflect on my practice make of the way I acted at the time?

### **3. Proposed actions following the event**

NOW WHAT? Trigger questions:

- What are the implications for others and me in clinical practice based on what I have described and analysed?
- What difference does it make if I choose to do nothing?
- Where can I get more information to face a similar situation again?
- How can I modify my practice if a similar situation was to happen again?
- What help do I need to help me 'action' the results of my reflections?
- Which aspect should be tackled first?
- How will I notice that I am any different in clinical practice?
- What is the main learning that I take from reflecting on my practice in this way?

**Source: Driscoll and Teh (2001: 100)**

## **APPENDIX I: Sample transcript**

### **Participant's Code: St-20-F-3**

I: So I welcome you to this interview session. Like I have said, feel very free, relax. I want you to reflect as much as possible on your clinical experiences in the various placements that you've been to. So for the first question I would want you to say something about the various experiences that you've had you may have been at KCH, you might have been to BT and other placements. What would you say about the clinical experiences you had as learning experiences? What was your perception of the clinical experiences?

P: In the first place I will start talking about my very first days in the clinical area. My very first days were so fine in a sense that I was excited, being the first days in the clinical area, putting on a uniform, having to have a stethoscope, a thermometer; all the tools that I am supposed to have. And then I was looking back at the days when I would see qualified nurses putting on their full uniforms and doing all the procedures in the ward. I imagined, this time around it's me and I want to do it. So I was excited, but unfortunately when I went right there practically doing the work, somebody else following me on my back telling me this is not what you are supposed to do, this is what you have to do. Having to puncture a vein for the first time, it was very hard and challenging and I thought maybe this is not what I am supposed to do, yes.

I: So it looks like when you joined you were full of excitement but when reality downed on you, you felt um.

P : Yes especially looking at for example in surgical wards when you have these patients coming in some of them coming with very big wounds, septic wounds. I had to make sure that I did the best thing in order to impress my lecturers, to impress my clinical supervisors, the qualified nurses who are there but sometimes it was not possible for me to do everything and because I was coming from secondary school whereby I had frequent breaks in between and then this time around I was really working, really working in the wards and looking at the state there I was saying ok so what time I'm going to knock off and everybody in the hospital was looking at me I have to do this. Sometimes guardians or patients would come to me and ask me questions of that I was not familiar with and didn't have the answers. So it was somehow somewhere so frightening and I was thinking I'm I going to do this? And when you go back into class you are given an assignment, you have to do the assignment but unfortunately you felt somehow somewhere you did not capture the material very well and you fail. You have to think back in the clinical area I was trying my best. Maybe some days you would be five to ten minutes late and this clinical supervise tells you have to go back or you have to write a report and you are thinking me, I am going to have this black list in my file. You are thinking this is going to disturb my whole learning experience. What is the file going to contain and how about by the end of everything what sort of academic credit I'm going to have and what will my parents think of me ? So all those things they are issues whereby in the past you never used to think about them but this time around you have to start



thinking about them, so it was challenging despite all the excitement that was there I also had this challenge to say I have to do my best in the clinical area, I have to do my best in class. But this whole thing is new and you think you were doing best in secondary school when you go to College you will also be doing best. Unfortunately you come here you just have everything it's just up at your hand and this lecturer is telling you do this and this lecturer is telling you do this. So it was just too much for me, I couldn't just capture everything. That's why I was let down to say maybe this is not what I am supposed to be doing.

I: So how did you cope finally because now you are in year three which means you can go on? How did you cope?

P: Ok I would go home during the holidays; my parents would ask me how the whole experience was? I would explain and somehow somewhere because I had this thing to say I want to be an air hostess, I will be putting on this fancy uniform or else I want to be in an office in the bank like my mother everyday putting on new shoes, all these things, high heeled shoes and now I have to be putting on flat shoes, white uniform every day. I don't have to let my hair dangle all those things and I would say I think this is not it. But by and by my parents would explain to me would actually say, you are not doing this for fun but in the end you will find that it's fun because you will get everything you want. This time around it's a profession, if you were in a, whether you were an air hostess, you would also have some limitations of which this time around you think it's ok, it's alright, it was going to be fine but when you go there you will also have to see all these limitations. But by now because everywhere you go you just have to feel some pain in order for you to get whatever you want. So if you have to focus on your degree then you have to go through this because when you qualify all these things will be part of you, you shall have internalised them and you will no longer have to worry about hair dangling around. So I coped and then I later on I learnt to love my work, I later on learnt to have to at least scheduling everything to make sure it fits; so that by the end of the day I have gone to the wards, I have done my work in class and I am fit. If I did not capture everything I wanted to capture, I know tomorrow I will have to start all over again until I capture it.

I: Um, ok, I just want to ask you one question, so at the beginning of it when you said you were excited, initially was nursing your first choice or?

P: Honestly it wasn't my first choice. I would say that my parents, as in my mother wanted to be a nurse but then she ended up not being a nurse, my sister wanted to be a nurse but then she ended up not being a nurse. So all these people wanted me to be a nurse, it was their wish, they wanted to fulfil their wishes on me and I grew up with this spirit to say I have to listen to my mother whatever she says I have to take it. I have to listen to my sister whatever she says I have to take it because they've grown up and they've gone through what I am going through now. So probably if they didn't make it, they know they have this hope in me say I can make it. I wanted these other fancy careers but then they thought it was not good enough for me, what was good enough for me was nursing. So if I did nursing I would become a very good nurse. Apart from that I would get a very good degree of which I would not have to be moving around, going around looking for a job. And apart from that because by

then I had lost my father so she told me you are going to take care of us. We don't have to be very sick in the hospitals and all those things like the way your dad was sick and we were running around in the hospitals. You would be the first person to say you are sick because of this and you are going to help us. So me I started getting this to say ok I don't want my mum to suffer and I don't want my sister to suffer and after all I want to be somewhere with a very good degree which is going to be marketable. So I came here because they influenced me.

I: Ok, alright, ok, so you started, there was excitement initially

P: Yes

I: Then somehow you became demotivated somewhere, then you talked of somebody following you. I still want to find out from you, what would you say about the experience as a learning experience. What is it that you have been learning? Has it been a learning experience?

P: It has been a learning experience the sole reason to say now I am in third year; I always tell myself to say when I was in first year, I would go into the wards not knowing what do I have to do. My lecturers have to be on my back do you have a log book? What is in your log book? Do you have objectives? I have to be asking my friends what is in your log book. What have you written in your log book? I honestly didn't know why I have to carry a log book. Why do I always have to carry that I'm I not old enough to say I know I am in the wards; this patient needs her drip to be dripping well or this client needs her wound to be cleaned, why should somebody tell me I need to have objectives. But now I know I have to have my objectives, why because I am a learner so because I am a learner I know my shortfalls when I am going into the clinical area I have to say ok, in my class schedule or in my syllabus I have to know this, I have to know this, I have to know this by the end of this year. So if I go into the clinical area I have to learn how to do things that's why I have to have a log book. I differentiate because then I didn't know why I have to have a log book but now I know I have to have a log book because by the end of the day I am supposed to go back into my logbook and say did I do this? Did I do this? If I didn't do it, ok why is it that I didn't do it? Tomorrow that will be my first thing. Like for example some few weeks ago I had not done MVA practical, yet in class we had done it and most of my friends had done it. So every day as I was leaving the hostels going to the wards, I had this thing to say I want to do MVA. It was unfortunate that the very first days of the week that I had planned I could not do it because I was allocated in room two and in room two most of the clients are those clients who have got infected or maybe septic wounds or maybe they have all these infections in their bodies so most of the times it is demanding; so I was not able to go into the MVA room to do a procedure and I had not actually watched somebody doing it. So I wanted to watch three times and then I should do it. And it was my objective say I want to do an MVA and by the end of the week I found that I had performed two MVAs. So to me it was quite so satisfying to say ok I have got this log book and I did the MVA, ok I wanted to do, to admit a client. I wanted to admit a client emergency and I also wanted to admit a client routinely as it is supposed to be in a ward. By now on Friday I am finishing now I am saying ok if by now probably

maybe they say you have qualified, you can go into the hospital, where would you like to work? I would say I can challenge I can work in a gynae ward, I am going to work in paediatric ward, I am going to work in female or male medical or surgical wards. So at least by now I feel I have learnt quite a lot, so it has really been a learning experience because even if I would say a client who is asthmatic has just come into the hospital, I would know what to do. A baby who has just come in with so many babies around, maybe it's a health centre; I would have to know what do I have to do. I need to assess the babies first of all to make sure, so that I tend to the very, very babies who are critically ill. The I didn't know but now I have learnt; IMCI, I have known all those things that I am supposed to know for me to perform effectively when I am being placed in a certain ward or in a certain health setting .

I: Ok, you have put some emphasis on the use of a log book ah you seem now to be appreciating it's use, do you have any challenges or problems presently using a log book?

P: Well sometimes I do, yah I still do in the sense that I don't know whether I would say it's lacking responsibility in taking the logbook or I would say well sometimes you just take some other things for granted. Because today I will have my log book by the time I am leaving sometimes I forget it because maybe my pockets are so small to accommodate even a log book so I would forget it in the clinical area. It means when I am going tomorrow I do not have the objectives for that day but at least now I know I need to have a log book. So I would have some gaps in my log book but still more I have my log book and I do make sure that I do have carry my log book and utilise it. So the problem that I used to have in the past is that I didn't have the knowledge but right the problem is sometimes I forget or maybe I would say I take it for granted, or maybe I would just say eh I need to knock off now I am tired, I would like to go and rest, Yah.

I: Mmh, other than documenting your objectives, what else would you document in your log book ?

P: When I have taken my log book in my pocket and I'm doing the nursing rounds or doctors rounds, I've met a certain condition of which maybe we did not learn in class, I document the condition, I document the management just in brief so that when I come back in that evening or that night, I can come into the library just to research on what that condition is all about just for my own knowledge.

I: Ok, so it's mostly, mostly what you document are the objectives and maybe what you are learning on various conditions. Anything else outside conditions of patients and objectives?

P: No I don't

I: Ok, have you heard anything about reflective practice?

P: I have and I have an experience whereby last year, I had to write a reflective journal.

I: Ok, here?

P: Here

I: Under ah what course?

P: Under medical surgical nursing clinical experience, clinical assessment and it was as part of clinical assessment tool. It wasn't for everybody but I was just so, I would say lucky enough because I was allocated in ward 4A and my clinical supervisor then was Mrs C, so she had given us that chance to say instead of us writing the case studies, we would have to write a reflective journal of the whole clinical experience and the conditions we had learnt, yes.

I: Did that experience help you?

P: It did because I had never thought or I had never heard of a reflective journal so that was my first time, it was challenging but after I had done it, after I had written it I felt ok, so I have gone a step ahead, a step further than my friends, I felt at least I was privileged enough. Say people don't know reflective journal, I'm not the only person in class who don't know a reflective journal so at least now I know what a reflective journal is all about, Yah.

I: Ah, since it was something that you were doing for the first time, how did you know how to go about it?

P: Ok, we had some guidelines, apart from having guidelines; we had to be going to her for consultation, yes.

I: Alright, ok, I want you to say something about ah the various clinical settings that you have been to, I know you may have been like now you are at gynae. You may have been to Blantyre; you may have been to any other ah placements, I want you to say something about these settings as learning environments. The classroom is a learning environment for theory, the ward setting is a clinical classroom; it's a learning environment for your clinical. So what can you say about the various settings you have been to as learning environments?

P: Ok, as, I would start with Blantyre campus. Blantyre campus is, the classrooms

I: No, I want you to look at the clinical settings, the ones that you've been here in Lilongwe, the ones that you've been in Blantyre, you may not need like to specify like BT and what but in general, what are the common issues that you would want to say about these settings as learning environments?

P: Ok, I wouldn't say they are all that bad; the reason why I am saying this is because we have the clinical supervisors; they are there from the College. This is very important because they have our objectives and we also have the objectives. So because they have our objectives, they have the guidelines on how to guide us when

we are doing specific procedures and not only that, but sometimes we may be absent from the clinical area, now because you are absent, probably the clinical supervisor who is allocated there as in specifically from the hospital, maybe the ward in-charge would think you are being deviant when you are not necessarily being deviant, but if the College clinical supervisor knows maybe you are sick or you have a certain problem, the clinical supervisor would definitely communicate with the clinical supervisor who is the ward in-charge at that clinical area, so this is very important, it's very good. And though I would also say on the other hand, sometimes the other clinical supervisors may make learning so hard in a sense that, for example, you are doing a procedure on a client. The clinical supervisor would come in the sense like policing you. So you are definitely scared, you cannot perform that procedure as it is expected just because you are anxious. Why are you anxious? Because the clinical supervisor is there but it's not all the clinical supervisors as I have said. So definitely, you have this preconceived idea, to say this clinical supervisor is a boss so I need to be very, very careful, because you are telling yourself I have to be very careful you are likely to make mistakes of which you are not supposed to make and how is this policing being done. The policing is being done in the sense that you are doing the procedure and the supervisor comes in, starts asking you questions for example, would ask you did you explain the procedure to the client. The clinical supervisor came in, in the middle of the procedure and instead of you having to finish the procedure first and then taking you somewhere else saying did you explain the procedure to the client? Did you do this? Did you do this? I noticed you did not do this. Right away there the clinical supervisor asks you did you explain the procedure to the client. And you say yes and then maybe he would say can you explain again. So this client definitely knows this is a learner and by that, he's already demotivated to say am I going to really get the care that I'm supposed to get. Next time you come alone without the clinical supervisor the client would not appreciate you doing that procedure on him or on her and sometimes you get this embarrassment. This embarrassment maybe correcting you in a very, you know, this way that you feel demotivated and all these guardians are looking at you; all the clients looking at you. Some would even get all these comments to say, ah They are just students; they don't know anything, I would prefer a qualified nurses to do that on me." Some have got the guts to say that, so it's so demotivating and soon after that you can no longer work and learn for the rest of the day because you keep thinking of that embarrassment. When you are working all these clients and all these guardians are looking at you, and you are thinking, what are they thinking now? What are they saying now? Sometimes it's so demotivating but all in all its quite very good because the nurses, the qualified nurses are there, they help us, you would ask them. Sometimes some of them well they feel they have also this preconceived idea and attitude to say KCN students are not all that good or KCN students have got this thing to say they are so full of themselves for reasons best known to themselves, but some are there to really guide us, to really help us and you would feel well, this is what nurses are all about. So you can also get all these comments from the clients to say eeh but there are some nurses really they are not supposed to be nurses. Well there are some other nurses when they are even giving you an injection you would feel eh I'm getting an injection but some of these nurses well they are good so well, maybe it's all this thing to say we are different so we've got different attitudes.

I: Ok what else would you want to comment ah about these settings as learning environment? Because so far you have spoken about the supervisors and then also the availability of nurses.

P: Yah, I would also comment on the availability of resources in the sense that the hospitals in Malawi, the government hospitals, they are not fully equipped. Because sometimes we are supposed to perform maybe wound cleaning using aseptic techniques but then they do not have maybe hydrogen peroxide, you are supposed to use hydrogen peroxide or maybe you are supposed to use eusol but they do not have these things. So you are supposed to improvise, instead of using all these liquids you are using normal saline and apart from that they may not have enough maybe sterile swabs and sterile gauze or sterile packs for cleaning the wounds so you are supposed to improvise. They may also not have maybe enough tourniquets, maybe when you are putting a drip you will not have a tourniquets. You are supposed to improvise and in the sense you are improvising using a glove. So all these things they make it so challenging, you also feel demotivated. Well how will I do it in a real setting whereby I have all the equipment? You qualify and probably you have never seen a real thing that you are supposed to use for that procedure. So for example in MVA you are supposed to use a teneculum but instead of using a teneculum maybe you are using a forceps. So you will qualify without having to know what a teneculum is and you go in a working environment you ask which is a teneculum, it's so funny and you will be like ok you are a qualified nurse and you do not know what a teneculum is. So it's challenging in a sense that the resources they are not all that enough, yah.

I: So what would you say ah in relation to this lack of resources, how is your competence and the performance of some of the skills which you should have already known by now?

P: Well, I don't think it really affects that much; though it affects but really it doesn't affect that much because I would just say it makes the learning so hard, we learn in a hard way but still more if you have this to say I want to learn, you still learn. Because what are all these nurses out there doing, they have gone through the same way and they qualify; some they go to UK and they start doing all these things. So well you would have this embarrassment to say I don't know what a teneculum is but in the end you learn it whether you are going to be a laughing stock or whatever but you still have to, ok, I will still want to know whether you will laugh at me or not but after you qualify you just don't know what the real instrument is supposed to be but you know you are supposed to use that type of instrument. So it doesn't really affect that much but still it affects in the sense that you learn in the hard way.

I: Ok, anything else you want to say about these settings as learning environments?

P: Mmh not much.

I: Not much

P: Yes, basically those are the three important points that I was supposed to state.

I: Ok, I want you to say something about memorable encounters during your various clinical placements. What memorable encounters have you had so far? These experiences you will always remember; they can be positive they can be negative.

P: Ok, as in, would you approve, ok would you accept all these personal or related to.....

I: You should just say whatever experience it was we will see what it was

P: Ok, the ah, ok, there was time I was allocated to be in a paediatric ward in BT then I had not gone into the paediatric ward before but then I wanted to be there so I went there with my friends, we were oriented by the nurse in-charge but then unfortunately there was this baby, it was in the nursery, the condition was neonatal tetanus. So I had never seen a baby with neonatal tetanus. Then this baby comes in the night that we were there during night duties, was very febrile and could not feed. The baby was so tiny, so, so tiny, so we had to put all a drip and all those pipes on the baby. Unfortunately the baby died in the morning but then to me all these things the jerking and you see this baby is supposed ok to respond to every sound, respond to every light, respond to every, every stimulus the baby responds. It was quite a shame to realise, to have heard the whole story how it happened because the girl, the mother was a girl, so the girl explains to say she was home and she started feeling all these labour pains. The granny said no, we still need to wait a little because if we go to the hospital we will take longer before you deliver. So the girl had to wait but then she could not wait any more until she delivered at home. And then the granny used a knife to cut the umbilical cord, we don't know what the granny put on the umbilicus but she just said she used a knife but then she said after some few hours it was still bleeding on the umbilicus; so the granny said she would put breast milk on the umbilicus and the girl really did that until the baby really got very sick after was it a day or two when she brought the baby to the hospital but she was alone. The baby came in was, could not suck, could not do anything was just crying and just responding all those stuff. So to me it was, ok, so really all these things do happen. It was a new thing to me, I had never seen that and it was something that I had only heard and we learnt in class and I had just read in books. To me it was a very, very, ok it was a good experience to say some of these things really happen in our own communities but we don't know them. So that was one of my memorable events. Apart from all these things that we normally meet them, frequently we meet them of course they are so strange and pathetic but we still meet them. But that one was something so special to me, to say ok just by the use of a knife cutting the umbilicus and putting in some breast milk, we've lost a baby. If the baby had gone, if the girl had gone to the hospital to deliver in the hospital the baby would still be alive. So I have learnt to say ok some very minute or very few or small mistakes that we do or we neglect we lose a lot of people and a lot of lives.

I: Ok, any other such memorable encounters?

P: Yah, no.

I: I still want us to focus on memorable encounters maybe you still have some, but

this time with specific individuals like maybe to begin with if you can say something about memorable encounters you have had with clinical supervisors. These are lecturers from the College, have you had any memorable encounters with them?

P: Yah

I: They can be positive, they can be negative.

P: Well normally we don't remember most of the positive things we remember the negative things because they affect us mostly so I remember there was a day I was allocated at Family planning clinic and the routine is by three o'clock the clients have finished and we are supposed to close the clinic. So me and my colleague we were allocated there. We went there in the morning, we had our objectives, we had met our objectives on that day. We were there from morning up until three o'clock when they close the clinic. So we decided to leave because they had closed the clinic. When we came here my clinical supervisor had gone for supervising us in the clinical area on to find that some students are missing that's when they enquired where are these students and the in-charge said they have been allocated to family planning clinic. They went there only to find that we were gone. But fortunately the matron and the nurse who were doing conducting the clinic on that day they were still there because they had to finish up, removing everything and packing everything that's when they asked them, I am looking for these students, that's when they said they were here but then we have closed the clinic so they are gone. Why are they supposed to be gone? They are supposed to go back to the wards where they have been allocated. And that was half-past three. So they said but when they were leaving they said they were going to pass through the wards so we thought they had gone to the wards we didn't know they were passing through the wards just to see their friends and leave them. So the clinical supervisor came here looking for us we weren't there and the clinical supervisor said we had to replace the whole day!

I: (laughter)

P: And I am thinking oh my God I have to replace the whole day or else I have to write a report. I am thinking I never, never want to have this report in my file. I don't ever want this to appear in my file and what do I do? You can imagine I didn't sleep the whole night and the problem with me the moment I am affected in that way, the moment something just diverts from normal, I get this diarrhoea, I get this bad headache and the night was just so bad. That day I did not my supervisor because I was staying in area 47 due to few space in the hostels so I had gone only to hear from my friends saying the supervisor was looking for you and you know when this clinical supervisor is looking for you it means there is something. And I am like my God what's the problem? You had actually left the ward earlier. So I am saying ok one and half hours remaining I am going to go and replace. And they say no, you are replacing the whole day. The whole day? I didn't miss the whole day I only missed one and half hours and I just didn't run away, I had gone there and they had closed the clinic because there were no more clients. No you were supposed to go and finish up at the wards that you were allocated at. So well its one of the memorable events to say eh don't be (Not clear) still more I had to go and replace the hours, yah.



I: So you had to do a whole day?

P: Yes I had to do a whole day shift because that was what my clinical supervisor said.

I: Where? At the Family planning clinic?

P: No at the wards, at 3A where I was allocated. Yah so it's well I don't know but it was just so stressful and I just didn't know what to do honestly.

I: Ok (laughter both I&P) Ok, ah, I want you to say something about the level of supervision by clinical supervisors, lecturers from the College. What is the level of supervision?

P: Well, I, they, ok each clinical supervisor has his or her own ways of supervising. So there are some they would leave you to, they will come to orient you, to be with you especially just for you to know what you are supposed to be doing for the first week and then they will be coming here and there in the middle of the allocation and they will also be coming frequently towards the end for evaluation. So I like these ones, I personally I like these ones because the moment they leave me they give me this autonomy and this responsibility to say I have to be doing this. I don't like them to be telling me today I am coming because I want to have this responsibility in me to say I want to be doing what I am supposed to be doing if I qualify because I believe by now I am old enough and I have to know what I'm I supposed to be doing, nobody has to be on my back pushing me you are supposed to do this. There are times you have your own personal issues they are affecting you psychologically you cannot work, you just can't work and you are supposed to be excused on that. There are times when during the week ends you feel like working but then because you have been pushed during the day you feel like uh I need to rest whilst maybe if you had your own responsibility to say I want to be working five days in a week and probably maybe during the week you had your own personal issues, psychologically you were affected you had to go on and say today I cannot work, I don't feel like working because I am having these problems will you excuse me at least for today. And then you own your own you can make that programme to say that day I wanted to do this and I didn't do. During the week end you have this responsibility to say I just want to go to the wards and I just want to be specifically doing this. So you are given the autonomy and you are given the responsibility of your own learning. You set your objectives and you achieve them. By the end of the day you are gone. Some of these lecturers maybe by half-past four, you have finished work, the qualified nurses have come, have gotten their report, clients are now stable, guardians are now in. You say ok maybe I need to rush back to the hostels to rest for this period, by six I would like to start studying but you can't come because it's not yet time for you to knock off. Yet you have already given hand over, that day you have this privilege to say today I can knock off earlier because I have done all my objectives, I have done my work, clients are stable, the handover has already been given but you cannot come. I feel like some of these supervisors who would have to pin on you and police you it's not all that good but there are some supervisors who would accommodate you to say ok have you done your objectives? I have done my objectives. Ok, this

time around, ok maybe half- past four well I think you can go and rest if you really you have done something (Not audible). And especially at third year, fourth year everybody has the responsibility because you know when I qualify I will be given a ward, if I'm in the ward all these people will be looking up on me to say ok a Sister could you help to, what are you going to do if you are a qualified nurse. It's you who is going to be embarrassed and ashamed because you don't know your work. So I think by now they should be able to give an allowances to say ok you have finished your work by half-past four, well you can go and rest and at six well you can go. Sometimes you would say I want to go back now at three because I want to come back at six. There are these clients who are mostly coming at six; by six maybe you are having these theatre things they are going on they are starting and you want to attend those but then you are so tired at five you can't so you are forced to stay behind. Sometimes you are overworked; you are overworked because you don't want to be overworked but because you are scared if my clinical supervisor comes in and finds me seating in a chair would ask me well what are you doing in a chair? Because you are just seating here you are going to write a report. You have been working the whole day, you are an individual, you are a person, you are also human you are bound to get tired you just want to rest. So I don't think anybody would just go into the wards and just be seating in a chair and yet you know you want to learn, yet you know you want to be a nurse someday. You want to have your own responsibility, you are only responsible, being responsible for a ward I don't think you would be so difficult well there are some who would be doing that but I feel it's their own responsibility by the time they qualify its them who will not be doing well, so yah. But there are also some who would be there day and night. Of course they would be there day and night but you would still be working with them as colleagues. They would not police you, they would not threaten you, they are there to help you, ok if you have problems. Such type of supervisors just enjoy working with students so they find it even fun to be working with students as their colleagues. So you would work with them the whole day by the end of the day you are gone. They would even say eh you have worked so hard today maybe you need to rest you can go at twelve and come back at two you shall have rested. There are also such type of clinical supervisors.

I: Ok, ah, there are a few issues I want us to explore from what you have said so far. You have mentioned of personal issues that might be affecting the student whereby the student might feel like I cannot learn today. What might be some of the issues that affect students personally like that?

P: Ok, there are a lot. I would say on my part because they would be the best because I know for example, maybe you don't stay maybe with your parents. Maybe you lost both of your parents and you are staying with relatives. Those relatives sometimes they have their own priorities you may not be the priority. So probably you have run out of pocket money or maybe you have some other issues at home of which you are supposed to be doing or some other responsibilities and you expect, ok even in school you need support. You need your sister, your brother or maybe whosoever is related to you at least to come and see you, if they cannot come and see you if they can call you, to be able to call you. At least to communicate just to find out how are you feeling and how are your studies but you don't get such type of things.

Sometimes you feel like do I really have a brother? Do I have a sister? Am I really belonging to somewhere or I am just here alone. So it's like you only get this moral support. Sometimes it's not necessarily financial support because well here at College we get three meals, major meals in a day and sometimes we get tea at ten. Not sometimes but always tea at ten and tea at four. So financial support whilst it's there it's needed for stationery and some of these things (Not audible). But then moral support is very important. You need to feel a sense of belonging it keeps you going because you feel you are loved. So sometimes you would tend to seek this from another person like for example you would seek it from a boyfriend and a boyfriend sometimes if you are not very careful, would take advantage of that especially if you are being so open enough to let the boyfriend know well me I am this and that, the boyfriend would take advantage of that in order to manipulate you, to use you as a puppet which is not very good. In the end you are psychologically affected you cannot concentrate to work or study in class.

I: Alright, ah the other issue you also mentioned the issue of workload. How does, what can you say about the workload in relation to your clinical learning?

P: Workload comes in as in, I feel; personally feel competence doesn't come in for you to be running around, running errands in other words if I may use that word for example, you are in the wards, the Sister asks you could you collect these blood samples and take them to the lab, could you please go to the kitchen and ask if this patient's food is available. Could you please go maybe to x-ray with this client, can you please go to ultrasound scanning with this client. Well I don't think that would make you a competent nurse because those are not mostly nurses, well I don't think so. You would do them because well you are there you can do them, but I think you have your own objectives to say ok I am supposed to know how to put up a drip, I am supposed to know how to resuscitate a client, I am supposed to know how to nurse a client who is unconscious all those things you are supposed to know. But for example, if go into the wards and you are supposed to be doing these things and at the same time running all those things by the end of the day you are so very tired. The nurse doesn't expect you to be found in the office seated or maybe writing even notes, you don't have to write notes in the office. You are supposed to write notes on the patient's bedside. Well some people have got these problems, physical problems they cannot stand the whole day; they cannot be running around for the whole day, they would want at least to rest. So you are forced to be doing that so by the end of the day you are so. You come here at five or six and you are supposed to be studying. You start studying just one page, you are dozing and this really affects our learning experience because it doesn't have to be that way so you are not competent in the sense that you would say ok I would rather get a client to the x-ray you know that when you go to x-ray at least you will find a chair somewhere and you will seat down, when you go the lab at least you are forced to wait for the results of that client because you know I will be seated somewhere. So all these things by the end of the day you find out you've gone to the lab, you've gone to the x-ray, you've gone to the kitchen, you've gone maybe to a certain department just to ask for something else but you did not perform the actual skill that you are required to have by the end of the day so you are not competent but you've been running around, you meet lecturers along the way, they say she is a very hard working student. But what has she done?

Has she achieved what she is supposed to have done by the end of the day? So I feel competence doesn't come for you to be running around the whole day but you need to have your objectives, you need to have fulfilled them but it becomes a challenge because nurses do not expect you to be doing only your objectives. You are supposed to be doing everything that is supposed to be done in the wards. They feel it's time for them to relax a bit. They are seated in their offices writing schedules, rosters. They will ask you even just to pick a call. They would pick a call and say ok can you go to theatre there is a patient you need to fetch. Ok there are maids out there, there are all these pink nurses they are also there, they also need (Not clear). So you would find them they are also having their meetings in the kitchen relaxing instead of helping us. Even this daily linen just to go to the laundry collect linen, or to go the laundry and at least deliver linen that is supposed to be washed, they are there they are just resting because we are there. So well we students run a lot of errands when we are in the hospitals; there is a lot of workload. Some of these they are not related to our objectives but you just say ok let me impress my supervisor, let me impress the ward in-charge at least by the end of this I need to get better marks. So yah, it also affects our learning because you are demotivated to say I don't think I haven't been working hard. This student is being ok labelled as a best student because she has been running a lot of errands in here. So well some of these things really demotivate us. You would think did I really deserve this mark? Ok whatever, as long as I get a pass whether it's just a pass but in the first place your objective was I don't want to get a pass, I want to get a distinction, I want to get a credit but some of these things would affect your learning so it's quite a demotivation really

I: Alright, ah the other issues that you have mentioned ah seem to be touching on ah characteristics of clinical supervisors. So what can you say about characteristics which facilitate your learning and characteristics which actually hinder your learning?

P: Ok, there are these policing characters or these characters; I don't know whether to say what would be the motive behind or the interest. Would the interest be to say I want to shape this student into a very good nurse? Or the interest would be I want to make this learning hard for her I don't know, that is very difficult for me to say. But then that policing or threatening attitude is really so hindering to a student to learn effectively. So I would prefer these lecturers or these supervisors who would work with you even the whole day, but then working with you in a sense as colleagues; if they have to correct you, they have to correct you somewhere else. Well sometimes you are doing a procedure and probably you are doing something that would be harmful to the client it would be best for the supervisor to say may I help, you will know I am doing something very harmful so you would give a hand to the supervisor just to finish up the procedure. Afterwards the supervisor would say that you were supposed to do it in this way that's why I said let me help you. So I would be very, very grateful to work with such type of a clinical supervisor even the whole day, even the whole clinical experience, even the whole learning experience in all my four years; I would prefer working with such type of a supervisor than the one who would come in and well destructing and demotivating you in front of clients. I don't mean to say I want to be like a qualified nurse; I don't want that but then I want to be told in this way that I would appreciate to say that I am being corrected and not just for

somebody to embarrass me yes.

I: Is that all about the characteristics?

P: Yah.

I: Ok, alright, ah how about any memorable encounters with clinical nursing staff?

P: Um no, it was just ah, no, no, no

I: Ok, still more, how about, what can you say about the level of supervision by clinical nurses?

P: Well I would say it's the same, there is a slight difference though in a sense that most of the nurses would say I mind my own business so they let the people do what they are doing if they feel what they are doing is contrary to their expectation. So they would have this attitude to say let them keep on do what they are doing I will know what I will be doing during evaluation. They would say ok, you don't want to go for the round, you don't want to go to the lab, you don't want to do this, ok, we will see what the end is going to bring. So you would see your marks by the time they are coming towards the end of evaluation ok so I am paying for not going for errands (laughter both P&I). Yah sometimes we have to pay with our own marks for not going for errands in the hospitals. But there are some honestly, they would actually talk to you privately if they feel you are deviating from normal; they would say my dear this is not the way nursing is all about. So apart from to say you have your own objectives I feel maybe you would help in this way. I realise you are a student; I know you get tired but could you assist me in doing this. So you say ok maybe I was really deviating from normal and well you compromise, yes.

I: Alright, ok how about also characteristics? What characteristics of nurses have facilitated your learning and those that have hindered?

P: Ok, there are some who would; they wouldn't even smile (brief laughter). You are coming in the morning, well I don't know who is supposed to start (laughter both P&I). Is it always the student who is supposed to start saying hi or sometimes they would I don't know. If you have been on night duty they would expect you to say how was you know the night at home? Ok you are welcome ok fine; you are supposed to say welcome. But when you are on day duty you are going, will you also say welcome or I don't know? So well because you are a learner you know you want to get these better grades so you are supposed to appease them. (laughter I&P) So you are forced to say hello even when it's not necessary; even if they would say hi when they are doing the work and it's not like they are even saying hi. You would say is she saying go away? Is she saying why? So after you say that you shut up until you get your report and by the end of the day you are gone. So those honestly they would not facilitate learning they would hinder learning; because you would be thinking eeh what have I done? And maybe she would even be talking to you and you wouldn't be listening because you would be thinking and she would have to shout on top of her voice saying, I am talking to you and you are like eeh say sorry.

She would even think so this learner is really a deviant and yet you were thinking, what have I done and why? Why did I do this and all this stuff? Because I remember I was allocated to dialysis unit so I go there, I knock and I find there are also these learners from a certain institution as in hospital. So I go there and I, because I didn't know they were coming from a different hospital; I didn't they were also learning. I go there I approach them and I tell them I want to learn. So she says ok seat there, let me talk to the owners of this department. So she approaches the owners of the department and say ok there are these students and they would also like to learn. She says let them wait for the owner and yet she is also the Sister of that ward so ok fine we wait. Then the matrons came in and as they came they greeted all of us because there were clients as well as guardians and us students and then after some time they converse, they joke along as they are working. After some time probably thirty-minutes that's when they say ok these are your students and they are saying whose students are those they should be yours and they are like no they are yours. So they make fun of us, they quite don't know what to say. And they ask us, so did you come here to learn or you brought a patient. We like we came here to learn. If you had came here to learn I don't see the reason why you have to be seating there idle. And we like sorry but we came here and we approached this nurse and she says we need to wait so we are waiting. We thought she was going to tell us now you can come and start doing this. No even if you are learning you have to be doing something. Even if you are waiting for something you are supposed to be doing something. So we are like sorry we didn't know we thought if she said wait if we touch anything she would be like you are disturbing our work so I told you to wait, wait. So now that you have said it we will start doing something. So we put on aprons and we were there just you know looking, everything is so quick, they are talking, the machines, everything is just like ok what is it? We thought we were in a laboratory whereby they are doing all those tests (laughter both P&I). Finally they, I don't know whatever happened for some reasons well God help us, at least they soften up and start teaching us. That was those other nurses who came to learn. So the matron they keep on listening and that's when they chip in. Then well the day went on like that but then it wasn't a good learning experience on that day. We learnt because in my heart I told myself well they are some people who would like to hinder my learning because they feel like you are a threat to them. So this thing came to me to say, if they think they are threatening me to learn, If they think they are protecting me or disturbing me or preventing me from reaching where they are then it's not it I will still reach there. So I tell myself I need to be strong otherwise I am not going to learn; it's not them who are going to lose it's me who is going to lose. So even if they have to hit me I have to learn so I had to you know tell myself I need to learn and I did; fortunately the day went on like that and I learnt, yah .

I: Was it just one day?

P: It was one day fortunately, thank God it was one day (laughter both I&P). Thank God it was one day. I learnt and I left oh thank you, thank you, thank you and I was like my God I'm going to be able to meet your daughter one day (laughter both I&P). That really doesn't facilitate learning (laughter both I&P).

I: Anything else about characteristics?

P: Well, but they are these nurses who would; they would work with you as colleagues. They understand you are students and for example, you are supposed to have your competence form; you need them to sign for you so they would make fun of it to say ok, you want me to sign this, I want you to be doing the procedure so ok they would ask you to do things that are on your objectives. So you would do them and she would happily do it. Even in the course of doing the procedure, she will be chatting. Even if during lunch hour you say you don't want to go for lunch sometimes you would you say I don't want to go for lunch you prefer staying with them in the office chatting until the day is gone. Those are some of the nurses you really, really love to do it. Sometimes they would admit to say I am sorry I don't know that maybe you should go and read and if you happen to read please come back tomorrow and tell me what you have read because I would also want to learn from you. So you would work with them as your colleagues and you would really chart stories that well you are tarrying and you would say at least we are meeting somewhere so those are nurses that facilitate learning.

I: Alright, ok, it's interesting (laughter both). Well what can you say about memorable encounters with fellow students?

P: Well (laughter) there are some students, well I would say, I guess maybe it's just that charity really begins at home in the sense that there are some students you actually say but eh these students I don't think when they qualify they would really be flexible as they are saying other fellow nurses should be flexible because maybe you want to go somewhere else, the nurses are there but you really have to go there or maybe one of your relatives or friends called to say I would like to come to the hospital and I would like you to help me maybe I need to see the doctor. So the person or the relative comes in and you say ok my relative is here, I would like to help the person and leave. You don't say bye to the nurses maybe because they are not there but your colleague is there so you tell your colleague. Could you please tell the nurse I'm gone I am supposed to do this and I will be back. The nurse asks ok where is your colleague. Eh I don't know where she is gone to. But she was here, but I don't know where she is gone. And you would be like would you really say that, didn't I say I'm going, but by the time you were leaving you did not say. But at least I had mentioned that this time around I will be leaving and you really want the nurse to have this bad picture of me, I don't think that's the way you are supposed to be doing. Well unless you don't know where I have gone really you can say I don't know but would really say eh that one I think she is gone. Well you are really, the nurse wouldn't have this positive attitude towards you so well there are also some of those colleagues and there are also some they would really prevent you from doing a certain procedure in the sense that you would say are you in MVA room? Yes today I am in MVA room, as you are doing those procedures, the moment they have started, please let me know I would also want to learn. So she is there, for some reasons she doesn't want you to know; whether she forgot, whether she just didn't want you to be there, whether, I don't know so some of those but I don't think she would just forget. Well even if she would forget it means she didn't put much effort to say my friend really has to know because even if it was just, the friend was in the hostel or somewhere else you would actually remember to say my friend wanted to learn this, I really need to tell my friend about this. They would meet a very strange condition

they would say ok I have this condition will you please come and see those of you who are interested but some they will just keep it to themselves; saying eeh they will know, they will see themselves when they meet this type of condition. So yah, even if when we are here maybe we have all these questions whereby some of the previous years people have written and we are supposed to go there and have the questions, sometimes when you are studying you would prefer just to answer the questions and then you go back to your notes just to see are you competent enough or do you know how competent you are. It happens that by the time you are studying maybe your colleague comes in to say I didn't have this question, could I just borrow I would like to at least copy and then also do it you would say well it's not mine, I have also just borrowed. I just want it for five minutes; it's not mine. Even your room mate would be hiding the notes, would be hiding those type of questions. They are very important to facilitate learning but some of them will hide information because they just want all themselves. They don't want two, three people to be on the dean's list; they just want themselves to be on the dean's list (laughter I). Sometimes you are a threat to them to say if she happens to get hold of this, she will even maybe do better than me so I prefer I get hold of this and she does better the way she does it so that at least I can reach her, well yah such type of students as well (laughter both I&P).

I: Alright, what can you say about caring for patients with ah AIDS, your personal experience like from year one to this present year

P: Ok, when I was in year one as I said I didn't know much so I was scared, very, very scared if they say ok this client is reactive, for me to get the courage to say I will go and obtain a blood sample, I will go and maybe the client is unconscious, I have to maybe feed through the NG tube, I would really, really be very, very, scared to say I don't know what else is there apart from the virus. What else, what other microorganisms Am I at risk of getting. And especially meningitis clients, those who are reactive and yet they are also meningitis, they've got this meningitis. I would really, really be so scared to go in there because I kept on thinking well it's an airborne infection, Am I not going to get it and for me to get the courage I would really make sure I am not allocated in that room. So well but with time, I learnt to say that time of exposure, different types of routes of exposure; so I can't just get it just like that. And even if I happen to prick myself, after pricking the client, well I am going to get PEP. So I learnt quite a lot to say; what if these people are my parents? What if these people are my sisters, my brothers how would I want them to be cared? I told myself, I will be in the position of the guardian of that client who is reactive. So I told myself I don't really have to be this; I felt well I can do it really yah, yah. If I am in a position to say, this time around I am in a position to say, what if I was the patient, or if I was the guardian; I felt I really need to help them, I really have to do what I am expected to do; the best I can do. So now I feel any client is the same reactive or not reactive, yah.

I: Ok alright, what can you say about stressful clinical learning experiences?

P: Stressful? (laughter both) ok totally they are bad, what else can I say? They are really bad there so.



I: What may have been stressful to you during your clinical learning?

P: Ok, there are times, I am supposed to have my own objectives right and I can't just reach the objectives on that day and maybe there are these doctors who come in to say I am going for a ward round so you need to prepare a trolley and you are supposed to be there with me during the ward round. And yet there are some of these clinical supervisors they will tell you, you don't have to be following these doctors you also have your own work to do. So you can be doing your own nursing round whilst the doctor is doing his own doctors round. And there are these doctors who will ask you questions during a doctors round so for me I feel it would be good for me to be doing the ward round because I learn as I am doing the procedure because sometimes I would go through the file, the doctor is gone I don't know the condition, I don't know what to respond as a person to that type of condition and I don't know who to ask. So well I have to come here and start searching; whilst if the doctor is there, and he tells what I have to do or the condition is all about, it makes my work easier. So it becomes stressful for me if the doctor is asking me a lot of questions on a condition I don't know, embarrassing me in front of clients. It really becomes so stressful. It also becomes stressful for me if there is maybe that day I don't have a very good day so it's so, so bad and everything, it becomes so stressful for me for that day; or maybe if there is too much work for us to do, so it becomes stressful, by the end of the day eh I am so tired it also becomes stressful. It also becomes stressful if my clinical supervisor who is acting as a police comes to the ward. The moment I just see the clinical supervisor, I am already stressed up, I am startled already, I don't know what to do, yah.

I: Ok, alright, what can you say about the assessments, the evaluations that you normally have at the end of the placement in relation to your clinical learning?

P: Ah I think they are worth it in the sense that they will come, they would ask you some of the questions like, how has been your clinical experience. They don't just solely depend on that, they would also depend on the nurses. Apart from depending on the nurses they would also depend on the times that they have been coming because today they would come and say I want to work with you; tomorrow they would come and say I want to work with this one, so by the end of the allocation, the supervisor must have worked with everybody in the clinical area. So having worked with all of you, apart from that, the information that the supervisor gets from the nurses, and also from the verbal communication during the small interview that takes in about eight to ten minutes. So I feel it's perfect and the case studies, though I don't really like the case studies because most of the students they will prefer well I would rather go to the library and write the case studies. So there are some of the things that we don't do you just say if the client is in this condition, what am I going to do, I will do this. So there are some they would say get your case study, the client that you have been doing, go to the bedside of the client and start explaining what the client came in here for, how many days have you worked for your client? How many, what are the procedures that you did on the client? They have to be documented and I like those ones because you have really done the work and you are presenting it to the lecturer. They would also ask you what is your opinion is. How do you think you have worked with the client? What other diagnostic tests were supposed to have been

taken on the client and why is it that they did not happen. So those are some of the different types of approaches how a supervisor would assess a student.

I: Earlier on you mentioned about these nurses who will say you will see.

P: Yes, because by the end of the clinical allocation they are given these professional evaluation forms. So they would ok maybe sometimes they don't even know you, they would have to ask you, by the way what's your name. Ok they actually, maybe you have somebody else who looks similar to you so she would think you are this person and think you are that person. So if you have been really available for her, running errands, she will definitely say oh this is a very good student; definitely she will start writing an excellent student, works very hard but if not she will say ah I have never seen this girl working here. If you ask her to do this she says I have my objectives I would like to achieve this so will you please excuse me on my own. She will definitely say eh this bad student she doesn't do well. That really affects because that's how she has evaluated you, yah. Having had all those grudges with you so she will definitely have to well I am going to pin you here (laughter both).

I: Is it a common occurrence?

P: Um, mostly it does.

I: Mostly so

P: Of course it doesn't happen like to every nurse because a ward would have three, four nurses. So if you are very unfortunate to have had that nurse evaluating you well, you would be in such type of a position, yah.

I: Ok, so if you look at the various grades that you've had so far, what would you say, do they reflect your real actual performance or you feel

P: Well there are times especially like in the past yes. I felt, honestly I am working so hard and I'm getting this, I don't think I was supposed to get this so I would think back why did I get this, or maybe did I have a certain encounter, a bad one with a nurse. I would find out that maybe at one point in time she had asked me I didn't see you after tea break where were you. We did this, or maybe this group thing to say ok for example, when I was in second year in BT campus there was this in-charge, she was, I don't know she had a problem or I don't know why but really we had a problem with her. The previous group that was there had complained, our group had complained. So our group was the one which presented the problem to the lecturer and the other in-charge was a supervisor. So they called her and they talked to her and that's when she comes to say ok, you had told your lecturer, you had told your supervisor to say I am not treating you well, I am being so harsh on you and I am being so hard on you ok we will see what is going to happen during your evaluation. And well really we would see these are the results but I think the lecturer shad at least this idea well these might not be good reflections of how the students have performed. So I wasn't the only person who was affected, it was the whole group that was affected. Probably maybe there was one or two who were failing at maybe

I: Well what can you say about ah the duration of your clinical placements in relation to your clinical learning? The duration.

P: Sometimes, ok like last year the duration was ah was quite good and I felt this year they have extended a bit. So having looked at it everybody is saying it is because of the management course that was just incorporated in together with paediatrics so we had just done them together instead of doing them in certain type of amount of weeks they've extended it to two so the holiday was sort of shortened a bit and the learning experience in class was also shortened a bit just to extend the clinical experience. So well maybe it's good enough because we are doing hands on work so I don't really find it a problem some of course find it a problem but I feel well after all we are going to be working in the hospitals we will be doing hands on so maybe we really need good practice so I find it ok, yah.

I: Ok, alright, finally I would want you to say something about what may have facilitated your learning in general now. You've touched on these issues as we were discussing other issues. But what would you say in general facilitated or hindered your learning.

P: What facilitated my learning was ah support, moral support, yah. I was this type of person who was so very much affected psychologically. (Not clear) up to now so I solely depended on moral support from my friends. So much as my relatives have been there but mostly I depended on moral support from friends. I have very good friends really who support me so much. And when I came here in College and the lecturers, some of the lecturers they happened to know me and they really gave me moral support and so it has really facilitated my learning. And I am attached to a very good spiritual group that really helps me so yah; it has really facilitated my learning. Sometimes I just don't believe how did I make it, yah.

I: Anything else?

P: Well some of the things that I found in the library like books, yah they also facilitated my learning.

I: Any hindering factors?

P: Well I just don't know why I don't like BT campus so yah third year is supposed to be in BT and BT campus to me is just this hospital thing. So I get this negative attitude when I get into the hospital and I'm like um I don't know well, so it was just so hard, yah.

I: Anything else that you want to share that I may not have asked you?

P: No.

I: Thank you so much it's been a pleasure having these discussions with you. God bless you.

P: It's been a pleasure too.

## APPENDIX J: Research Budget and Justification

### A Travel Expenses

This includes travel expense from Edinburgh to Malawi

Name	No. Of Trips	Air travel	Amount in MWK <sup>169</sup>
Mrs G Msiska	1		K120,181.00
<b>Subtotal</b>			<b>K120,181.00</b>

### B Printing Expenses

This includes costs for printing copies of the proposal for submission initially to KCN Research and Publications Committee (RPC) and secondly to College of Medicine (COMREC) for ethical approval

No of documents	No of pages per document	Cost per page	Reason	Amount in MWK
5	80	K10	Submission to KCN RPC	K4,000.00
5	80	K10	Submission to COMREC	K4,000.00
<b>Subtotal</b>				<b>K8,000.00</b>

### Colour Printing

This includes cost of colour printing for the cover page for copies of the proposal submitted to COMREC

No of documents	No of pages per document	Cost per page	Amount in MWK
5	<b>I</b>	K100	K500.00
<b>Subtotal</b>			<b>K500.00</b>

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<sup>169</sup> Amount in MKW refers to amount in the Malawian currency

**C Binding Expenses**

This includes cost of binding copies of the proposal for submission to KCN RPC and COMREC

No of documents	Cost per document	Amount in MWK
10	K130	K1,300.00
<b>Subtotal</b>		<b>K1,300.00</b>

**D Expenses for audio taping**

Name of Item	No of items	Cost per item	Amount in MWK
Tape recorder	1	K14,900.00	K14,900.00
Audio tapes	30	K150.00	K4,500.00
Duracell Batteries	3 pairs	K950 per pair	K2850.00
<b>Subtotal</b>			<b>K22250.00</b>

**E Expenses for transcription**

This includes the cost of transcribing the 20 interview sessions

No of transcriptions	Cost per transcription	Total Cost
20	K5,000.00	K100,000.00
<b>Subtotal</b>		<b>K100,000.00</b>

**F Processing fee**

This includes amount of money paid to COMREC for ethical approval of the proposal

Fee in US Dollar	Amount in MWK
\$100	K14,199.77
<b>Subtotal</b>	<b>K14,199.77</b>

### Summary of Costs

Price Components	Amount in MWK
Travel expenses	120,181.00
Printing Expenses	8,000.00
Colour Printing Expenses	500.00
Binding Expenses	1,300.00
Audio taping Expenses	22250.00
Transcription	K100,000.00
Processing Fee	14,199.77
<b>Total Research Budget</b>	<b>MKW 266,430.77</b>